PROVIDENT AMERICAN
INSURANCE

AUTHORIZATION TO OBTAIN INFORMATION

POLICY NUMBER: _____

I authorize the following to give information (as defined below) to Provident American Insurance Company or any person or entity acting on its part: any medical professional, medical care institution, insurer, reinsurer, government agency (including departments of public safety and motor vehicle departments), or employer. "Information" means facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, or other insurance coverage Provident American Insurance Company deems appropriate to evaluate claims for benefits during the time this authorization is valid. I understand that any disclosure of information to Provident American Insurance Company for the purpose of evaluating claims for benefits for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be re-disclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Provident American Insurance Company to evaluate claims for benefits.

I understand that I may revoke this authorization at any time, except to the extent that (1) Provident American Insurance Company has taken action in reliance on this authorization, or (2) other law provides Provident American Insurance Company with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to Provident American Insurance Company, Claims Department, 10501 North Central Expressway, Suite 200, Dallas, TX 75231.

Unless otherwise revoked, I agree that this authorization will expire two years from the date indicated below.

I agree that a copy of this authorization is as valid as the original.

_____

SIGNATURE (IF CLAIM IS FOR A MINOR, PARENT OR LEGAL GUARDIAN MUST SIGN) **DATE**

_____

PRINTED NAME

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be attached.

Mail this with your claim form

MAIL TO
PROVIDENT AMERICAN INSURANCE COMPANY
10501 NORTH CENTRAL EXPRESSWAY, SUITE 200
Dallas, TX 75231
PHONE: 800.933.9456 OR 214.696.9091 FAX: 214.237.8664