

Verbal Authorization Information



If you provided an authorization by telephone, text of that voice authorization is reproduced below for your records. The authorization allows us to begin obtaining information needed to evaluate your claim. You may revoke your voice authorization at any time by calling the Claim Manager handling your claim.

I authorize any physician, medical professional, hospital or other medical facility, pharmacy, employee assistance plan, insurance company, health maintenance organization or similar entity to provide access to or copies of any information about my health or other information relating to me, to any individual or entity who provides services to or insurance benefits on behalf of my employer's employee health & welfare plan(s) ("the Plan"), including but not limited to Life Insurance Company of North America and its insuring affiliates and any entity providing assistance to them under their Social Security Assistance Program. Information about my health may relate to any disorder of the immune system including, but not limited to HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information obtained with this authorization will be used for evaluating and administering my coverage, including any claim for benefits, or otherwise providing services related to or on behalf of the Plan, which may include, but is not limited to, assisting me in returning to work, Plan administration and identifying other coordinating benefits for which I may be eligible.

If my employer [union, group association] sponsors any other plans, whether or not underwritten or administered by a Cigna company, the information and/or records obtained may also be shared with the underwriting company (insurer) or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

For any claim for insurance benefits, this authorization is valid for the shorter of 24 months or the duration of my claim. For all other permitted disclosures, this authorization is valid for one (1) year from the date of execution. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I do not have to give this authorization. If I choose not to give the authorization - or if I later revoke it - I understand that the Plan, insurers or other providers of services to or benefits on behalf of the Plan who rely on the authorization may not be able to evaluate or administer my claim for benefits or request for services, and that this may result in a denial of my claim for benefits or request for services.

I understand and agree that by saying "YES" at the end of this recorded authorization, I have agreed to the terms of this authorization and that it will be as valid and effective as if it were physically signed by me. I also understand that the use and further disclosure of information disclosed hereunder may no longer be subject to protection under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, though it may still be protected under other applicable privacy laws.

Company Names: Life Insurance Company of North America, Cigna Life Insurance Company of New York, Cigna Worldwide Insurance Company, Great-West Life & Annuity Insurance Company, First Great-West Life & Annuity Insurance Company, New England Life Insurance Company, Alta Health & Life Insurance Company and Connecticut General Life Insurance Company.

