

Authorization for Disclosure of Health Information

Member Name: _____
Member Social Security Number: _____ **Date of Birth:** _____

As described below, I hereby voluntarily authorize Best Life and Blue Cross & Blue Shield of SD insurance companies and their affiliates to disclose my individually identifiable health information and that of my covered dependents. I understand the information will be disclosed only to the person(s).organization(s) listed below, for the purpose of administering insurance unless otherwise permitted by law.

Agent Name: Alan C. Bernhagen
Company: Life Security Agency
Agent/Company
Representatives: Fay Peterson
Dotti Dean
Sally Austin
Toni Speckman

I understand that the information I have authorized the above mentioned companies to disclose may include confidential personal claims administration information about my covered dependents or me.

Right to Contact

I give approval to Life Security Agency, its Agents and Staff to call on behalf of my insurance matters.

This approval will continue until I rescind in writing this Privilege.

Signature of Member

Date