aetna®

Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Aetna International
Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization (S*ee Section 8)*.

1. Member Information (Information About Person For Whom This Authorization Is Requested.)

Last Name/Surname	First Name	Middle Initial

Claim Number	Year of Birth	Daytime Telephone Number (include area code)

Street Address	City, State and ZIP, Country

2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim.

3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna):

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

4. If you prefer to authorize the request of only selected categories of information, please indicate below which types of information may be disclosed. (This section completed by Member)

☐ Health (This includes medical, dental, pharmacy, vision, and flexible spending account information)
☐ Behavioral Health (e.g., mental health, drug and alcohol abuse treatment)
☐ Disability ☐ Life Insurance ☐ Long Term Care ☐ Workers' Compensation
☐ Other: *(please specify)* _____

5. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations):

Service Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, workers' compensation professionals, diagnostic facilities, hospitals, clinics (including individuals or facilities which provide rehabilitation services or treatment.)

6. Expiration of this Authorization:

This authorization is valid throughout the processing and any term of your disability claim unless you indicate a shorter period below.

_____ through _____
mm/dd/yyyy mm/dd/yyyy

Please review and complete important information on the reverse of this form.

Employee Name

7. Important: Your signature below means that you understand and agree to the following:

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations.
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers.
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization.
- You may receive a copy of this form if you request it in writing from the address listed below.

8. Signature of Member or Legal Representative

Signature of Member or Legal Representative	Date
Print Name	

If not the Member, describe your relationship to the Member:

☐ Caregiver
☐ Legal Representative
☐ Other: _____

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

NOTICE TO RECIPIENT(S) OF INFORMATION (Section 2. above):
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individuals' family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

Return this completed form to: **Aetna International**
Attn: Disability Claims Processing
PO Box 14560
Lexington, KY 40512-4560
USA

Telephone Number: **866-326-1380** Toll Free Within U.S.A.
800-231-7729 Toll Free - Outside U.S.A. (via AT&T Direct Access Code)
813-775-0190 Direct or Collect outside U.S.A.

Fax Number: **855-806-0522** Within U.S.A. and via AT&T Direct Access Code from any country