Authorization To Obtain Information

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

Complete and sign the form using BLUE or BLACK ink.

Control Number: ______________________________

Employee Date of Birth *(MM/DD/YYYY)*: ______________________________

Employee Gender: ☐ Male ☐ Female

I ____, SSN/ID # ________________________________,
(please print full name – Last/Surname, First, Middle Initial)
hereby authorize any insurance company, third party administrator, government organization, employer and any of their agents performing services relating to any employee benefits or workers compensation or other organization, institution, or person that has any records or knowledge about me containing the following to release the information to the Aetna and/or its duly authorized representatives or agents:

- **Financial information,**
- **Information pertaining to my credit history,**
- **Information pertaining to my academic performance, credits earned, or school-related activities,**
- **Other insurance benefits, or,**
- **Employment information and history (including job duties and earnings).**

I understand that the information obtained by use of this authorization will be used for the purpose of evaluating and administering my claim for disability benefits.

This authorization is valid for the term of the policy or contract under which a claim has been submitted.

I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

I further authorize the Aetna and/or its authorized representatives or agents to request reports and information from the Social Security Administration regarding benefits, earnings and employer information, and any award, disallowance or termination relating to benefits.

Print Name (*Last/Surname, First, Middle Initial*)	
Signature of Employee	Date Signed *(MM/DD/YYYY)*

If the person signing this authorization is not the member, describe relationship to the member.

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If this authorization is being signed by the member's legal representative, you must furnish a copy of the Power of Attorney or other relevant document authorizing you to act on the member's behalf.

Mail this completed form to:

Aetna International
Attn: Disability Claims Processing
P.O. Box 14560
Lexington, KY 40512-4560
USA

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