Platinum Supplemental Insurance, Inc. and/or Platinum TPA, Inc.
137 Main St, Dubuque, IA 52001
1-877-822-0582

HIPAA AUTHORIZATION
To Permit Limited Use and Disclosure of Health Information

Upon presentation of this signed Authorization, I authorize State Mutual Insurance Company, without restriction, to release the following protected health information: (i) my name, policy number and contact information when I am on claim with regard to any limited benefits policy, cancer, heart attack and stroke insurance policy, hospital indemnity policy; or accident policy that I might have with Company; and (ii) insurance coverage matters including the amount of benefits paid concerning any claim I file in connection with any of the above insurance policies.

Platinum Supplemental Insurance, Inc. and/or Platinum TPA, Inc., Iowa business corporations with principal offices located in Dubuque, Iowa, including any of its employees or agents, is authorized to receive and use the above information for the purpose(s) stated below.

Purpose of Release of Information:

To contact me in connection with testimonials related to the insurance product, any claims and service provided to me.

Right to Revoke. I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to Platinum Supplemental Insurance, Inc. and/or Platinum TPA, Inc. at the above address. Revocation requests must be sent in writing to the attention of the Claim Department Manager. I understand that the revocation is only effective after it is received and logged by the Claim Department Manager.

I further understand completion of this HIPAA Authorization for release of the information set forth above is voluntary and that payment will not be conditioned upon my choice not to sign.

This Authorization is valid from the date signed and will remain in effect for the first to occur of: (i) 24 months from the date hereof; or (ii) termination of the policies that I may have with State Mutual Insurance Company

I understand that if the person or entity that receives my information is not covered by the federal privacy regulation, my information may be re-disclosed by such person or entity and will then no longer be protected.

I understand that I am entitled to receive a copy of this Authorization.

I acknowledge by my signature below that I have read and understand this Authorization, that it accurately reflects my wishes, and that a photocopy, facsimile, or other electronic copy is as valid as the signed original.

If you are signing as a personal representative, please read and sign below:

I _____hereby certify and attest that I am the duly authorized personal representative of _____, that my relationship to the policyholder/insured is _____ , and that I have the lawful authority to enter into this authorization on behalf of the policyholder/insured. I have read the provisions set forth in this authorization and agree that State Mutual Insurance Company and/or Platinum Supplemental Insurance, Inc. and or Platinum TPA, Inc. may use and/or disclose the aforementioned information for the purpose set forth herein.

_____
Please Print Name of Insured or Personal Representative

_____
Signature of Insured or Personal Representative and Date