## Authorization to Disclose Health Information to My Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that this information will be used by my employer, and its broker, to monitor and manage the disability benefits program provided under my Group disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information which may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

**This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:**

ATTN: Group Disability Management Services
Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175-0001
Or
Fax 402-997-1865
Or
Email SubmitGrpDisInfo@mutualofomaha.com

**I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.**

**I understand that I am entitled to receive a copy of this authorization. A copy of this authorization is as effective as the original.**

_____
(Printed Name and Address)

_____ _____
Signature Date

**or**

**If Applicable**: I am the legal representative of the person whose financial and health information is to be disclosed, but I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

Signature of Legal Representative: _____

Type of Legal Representative: _____

Date: _____

## RETAIN A SIGNED COPY FOR YOUR RECORDS