The **Federal** Long Term Care Insurance Program™

FLTCIP Authorization for Disclosure of Information

Insured's name

First name M.I. Last name

Address

City State/Territory

Country Zip/Foreign postal code

Date of birth ___ / ___ / ___
Month Day Year

I, the insured named above, authorize Long Term Care Partners, LLC (LTCP), to disclose information about my insurance coverage and benefits under the Federal Long Term Care Insurance Program (FLTCIP), including demographic information, billing and payment information, claim and related medical information, and other information related to the FLTCIP, to the person(s) listed below. This will allow that person(s) to assist me in matters related to my coverage under the FLTCIP.

Name	Relationship	Phone number
		– –
		– –

I understand that this authorization is voluntary. Unless I revoke the authorization, I understand that it is valid until the later of 1) one year from the date this form is signed (if I do not yet have coverage nor become insured) or 2) one year from the date I no longer have coverage under the applicable account (if I am insured or become insured), at which time it will expire. I understand that I may revoke this authorization at any time by notifying LTCP in writing at: **Long Term Care Partners, LLC, Attn: HIPAA Privacy Office, P.O. Box 797, Greenland, NH 03840-0797**. Revoking this authorization will have no effect on any information released in reliance on this authorization before LTCP received the revocation. I further understand that LTCP will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

I understand that the individual(s) listed above may redisclose any information received. Once information is disclosed to the individual(s), I understand that the information may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) regulations and other applicable privacy laws.

Signature (insured or legal representative) ______________________

Date signed ______ / ______ / ______
(Required: mm/dd/yy)

Note: A handwritten signature is required. If signed by a personal representative of the insured, please describe the authority under which the personal representative is authorized to act and enclose any related documentation (e.g., copy of your durable financial power of attorney):

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Please return your completed form by fax to **1-866-513-2674** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.

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