Authorization for Disclosure of Information—Compliance

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 (LTCP), LLC, 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

Name | Relationship | Phone number

I understand that this authorization is voluntary. I understand this authorization will be valid until the earlier of: such time as I no longer have this coverage under the FLTCIP (at which time it will expire) or such time as this authorization is revoked by me. 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 re-disclose 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 person or legal representative) _____

Date signed _____ / _____ / _____

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., legal copy of your power of attorney):

_____

_____

Return your completed form to:

Long Term Care Partners, LLC | P.O. Box 797 | Greenland, NH 03840-0797 | Fax: 1-603-433-3811

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

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

John Hancock