AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I, _____ *(covered person's name)*

residing at _____ *(address)*

give **you** my permission to give Dunn and Associates Benefit Administrators, Inc. any information about me and/or my dependent(s) necessary for:

- ☐ Determining eligibility for insurance
- ☐ Determining eligibility for benefits
- ☐ Risk classification
- ☐ Detecting or preventing fraud or misrepresentation
- ☐ Scientific research projects or audits
- ☐ Determining Case Management Needs

The word "**you**" refers to any organization or person that has records or knowledge about me or my medical history, mental or physical condition, diagnosis, treatment or prognosis. This includes my employer, any provider of health care, and another insurance company where I have purchased insurance, consumer reporting agencies, the Medical Information Bureau, Inc. and other such insurance-support organizations. This information may also be given by Dunn and Associates to its legal representatives, reinsurers, consumer reporting agencies, or its other insurance-support organizations. It may also be given to any life or health insurance company with which I might apply for insurance.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information", is defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

This authorization is effective for any minor dependents proposed for insurance. This authorization can be used for two (2) years from the date below unless revoked in writing with notice to you and Dunn & Associates. I know I can receive a copy of this authorization and can elect to be interviewed if an investigative consumer report is prepared.

I agree that a copy of this authorization may be considered as valid as the original.

Signed this _____ day of _____, 201_____

_____ _____

Insured's Signature Insured's Group ID

_____

Name of all Dependents Covered Under this Authorization

Return completed from to: Dunn & Associates
Mail: PO Box 2369 Columbus, IN 47202-2369 - Fax (812) 378-9967 - Email: info@dunnbenefit.com