

Student Verification & HIPAA Disclosure Form



US HEALTH AND LIFE
INSURANCE COMPANY

8220 Irving Road
Sterling Heights, MI 48312
1-800-211-1538
www.ushealthandlife.com

A. Student Information and Affirmation

To be completed by student

I, _____
First Name M.I. Last Name Student Number

authorize _____ to release to US Health and Life
The institution at which you are currently a full-time student

Insurance Company, the information listed below.

Student Signature Date

B. Confirmation of Full-Time Status

To be completed by School

For the current semester, beginning _____ and ending _____,
Date Date

the student listed above is enrolled for _____ credit hours, which is considered

by _____ to be; Full Time Part Time.
School, College or University

This same student is considered a Freshman Sophomore Junior Senior

I affirm that I have completed this form to the best of my knowledge and ability.

First Name Last Name Title

Authorized School Representative Signature Date

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C. Employee Agreement/Authorization to Release HIPAA Medical Information

I have read the notice explaining the use of the Medical Information Bureau. I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, or Consumer Reporting Agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and or HIV/AIDS test results or diagnosis and/or treatment of me or my named dependents and other non-medical information of me or my named dependents, to give to US Health and Life Insurance Company or its legal representative, any and all such information.

I understand the information obtained by use of this authorization will be used by the insurer to determine eligibility for insurance, and eligibility for benefits under any existing policy, for myself and my named dependents. Any information obtained will not be released by the insurer to any persons or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my application for insurance, for any claims, or as may be otherwise lawfully required or as I may further authorize.

I understand that I may request a copy of this authorization at anytime.

Your Privacy Is Protected

US Health and Life Insurance Company, like other health insurance companies, sometimes evaluates present and past medical history of applicants to determine their eligibility for certain policies. With US Health and Life Insurance Company, this evaluation is limited to specific insurance policies; and the applications for those clearly show this requirement. I authorize the use and disclosure of my protected health information as described below. My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

US Health and Life Insurance Company is authorized to use or disclose my protected health information. My protected health information will be used or disclosed only for the purposes of administering the insurance certificate subject of this application. I understand that if I refuse to sign this authorization that US Health and Life Insurance Company may refuse to enroll me or determine that I am not eligible for benefits. I understand that I may revoke this authorization at any time by sending a written notification to US Health and Life Insurance Company at 8220 Irving Road, Sterling Heights, MI 48312, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective: (i) for information that US Health and Life Insurance Company already has used or disclosed, relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

Any information you give USHL or its insurer regarding your insurability will be treated strictly confidential. USHL, or its insurer, may make a brief report on information received with your application to the Medical Information Bureau. (A nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. P.O. Box 105, Essex Station, Boston, MA 02112. Phone: 617-426-3660). The Bureau, upon request from a member company to whom you may apply for insurance or to whom a claim for benefits may be submitted, will supply the company with such information. If you ask, the Bureau will arrange disclosure of the information in your file and you may seek to correct any inaccuracy in accordance with the Fair Credit Reporting Act procedures.

Employee Signature: _____ Date: _____

Employee Social Security Number: _____

Employee's Phone Number: _____

Employee's Group Name _____

Dependent or Student Signature: _____ Date: _____

Dependent or Student Social Security Number: _____

FORM(S) MAY BE FAXED: ATTENTION ENROLLMENT DEPT (586) 693-4820