I hereby authorize The Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee.

DATE __________________________ SIGNATURE OF PARENT OR GUARDIAN

(Dense text: Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.)
AUTHORIZATION
To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that First Agency may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

(Please Print) Name of Patient

______________________________  ________________________
Signature of Patient if claimant is 18 or older  Date

(Please Print) Name of Authorized Representative, or Next of Kin

______________________________  ________________________
Relationship of Authorized Representative or Next of Kin to Patient  Date

______________________________
Signature of Authorized Representative or Next of Kin

______________________________  ________________________
Date