AUTHORIZATION TO RELEASE INFORMATION-LEGAL PURPOSES

MAIL TO: Continental American Insurance Company
P.O. Box 427
Columbia, South Carolina 29202

CALL: 1.800.433.3036 (toll-free)
FAX TO: 1.706.596.3270 (Legal Dept.)
EMAILTO: legaldocumentrequest@aflac.com

Primary Certificateholder's Name:	**SSN**(optional)	**Date of Birth:**
Certificate Number(s):		
Address:		
Name of Individual Subject to Disclosure (if not the primary certificateholder):		**Date of Birth:**
Relationship to Primary Certificateholder: ☐Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		

CAIC May Release Information To The Following:

Name: RECORDS DEPOSITION SERVICE P.O. Box 5054, Southfield, MI 48086-5054

Relationship to Individual Subject to Disclosure: ☐ Attorney ☑ Other (explain): 3RD PARTY COPY SERVICE

Authorization and Indemnity: I, the undersigned, hereby authorize Continental American Insurance Company (CAIC) or any person or entity acting on its part to release any information (defined below) concerning me or any of my certificate(s) to the person or entity identified. "Information" includes information in CAIC's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting or a claim for benefits), and non-medical financial information (including, for example, policy premium and status information).

- I authorize and direct Aflac to release Information to the person or entity identified via: (check all that apply)

Delivery Method	**Mail or Fax To:** (Please type or print legibly.)
☐ regular mail/carrier	
☑ electronic mail (email)	REQUESTS@RECDEP.COM
☑ facsimile (fax)	248-357-3337

- ____ **Initial** If email is selected; I understand that there may be some level of risk that the Information in the email could be read by a third party. I do hereby agree to indemnify and hold harmless CAIC, its employees, and agents from any unauthorized access of protected health information while in transmission and after delivery to the indicated email address.

Purpose, Rights, and Expiration:

- I understand that this Information will be used for purpose of legal representation and/or litigation.
- This authorization shall remain in effect for one (1) year from the date hereof, unless revoked by me. I understand that I may revoke this authorization at any time, except to the extent that Aflac has taken action in reliance on this authorization. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address above.
- I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Notice: I understand that CAIC is not conditioning payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and if the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. The undersigned hereby waives any restrictions on disclosure imposed by law on Aflac and releases CAIC, its officers, directors, employees and agents from any liability associated with the release of any information pursuant to this authorization.

- **If records are on an adult dependent (e.g. spouse, child over 18), the dependent must sign this form.**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Primary Policyholder's Signature	Date Signed	Dependent's Signature	Date Signed

Legal Representative's Printed Name	Legal Representative's Signature	Legal Relationship	Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)