Send the completed form to:
Capital BlueCross
PO Box 773131
Harrisburg, PA 17177-3131

DISCLOSURE AUTHORIZATION FORM

Instructions: Read the information below carefully. Sign and date the appropriate fields. Have your spouse and/or dependents age 18 or over sign and date the form also.

By signing this form, I authorize Capital BlueCross to collect and process my individually identifiable health information described below so that Capital BlueCross has the information it needs to determine the premium to be charged to my employer, and to conduct clinical management activities if I enroll in Capital BlueCross coverage.

By signing this form, I also authorize the insurers and health plans that have covered me in the past, and pharmacy benefit managers and reinsurers that have performed services for the insurers and health plans that have covered me in the past, to disclose claims records and other health information. Such information may include information protected by state law including, but not limited to, HIV, mental health, and substance abuse.

I understand the nature of this release and I understand that I can refuse to sign this authorization. Capital BlueCross will not refuse to enroll me or deny me benefits if I refuse to sign this form. This form does not apply to and I do not authorize disclosure of psychotherapy notes. I understand that, with respect to any of the parties described above, I may revoke this authorization at any time. To revoke the authorization for any of the parties named above, I understand that I must give written notice to that party, and that to revoke the authorization for all parties, I must give written notice to each of my former insurers, health plans, pharmacy benefit managers, and reinsurers, in addition to Capital BlueCross. My revocation will not affect the rights of anyone who has acted in reliance on the authorization prior to receiving notice of my revocation. Unless revoked earlier, this authorization will be valid until the initial underwriting determination is made by Capital BlueCross. I understand that the information covered by this form, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

AUTHORIZATION SIGNATURES

Signature of Proposed Insured (Subscriber or Subscriber's personal representative*) Date

Signature of Other Proposed Insured (Spouse or Spouse's personal representative*) Date

Signature of Other Proposed Insured (Dependent age 18 or older or Dependent's personal representative*) Date

Signature of Other Proposed Insured (Dependent age 18 or older or Dependent's personal representative*) Date

*An individual's personal representative is an individual's legal guardian, or someone who has power of attorney over the individual's health care decisions. A copy of the power of attorney or other court initiated documents should be included along with this form, if applicable.

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White - Capital BlueCross • Yellow - Subscriber Copy

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