WINDSOR LIFE
INSURANCE COMPANY
1345 River Bend Drive Dallas, Texas 75247 fax 214-528-2777

APPLICATION FOR GROUP CRITICAL ILLNESS BENEFIT CLAIM

CLAIMANT'S STATEMENT

1. PERSONAL INFORMATION

Group Policy Number _____

Name of Insured: _____ Date of Birth: _____
Last Name First Name M.I.

Telephone Number: _____ Social Security No.: _____

Address: _____

_____

2. DETAILS OF CRITICAL ILLNESS:

a) Describe your disease or condition: _____

_____

_____

Date of diagnosis: _____

b) When did the first symptoms appear?
Month Day Year

_____

c) When did you first consult a physician for this disease or condition? _____

_____

Name & address of that attending physician: _____

_____

d) Provide details and dates of tests or exams to confirm the diagnosis: _____

_____

_____

e) Describe current and past treatments for this disease or condition:
Type of treatment Hospital / Institution / Treating Physician Dates

_____

_____

_____

APPLICATION FOR GROUP CRITICAL ILLNESS BENEFIT CLAIM - PAGE 2

f) Have you previously suffered from or received treatment for the same or a similar disease or condition? If yes, provide details and dates: _____

_____

_____

3. MEDICAL CONSULTATIONS

a) Name and address of your personal physician: _____

_____

b) Names, addresses and dates seen by any other physicians or specialists for this disease or condition: _____

_____

_____

_____

c) Names and address of any hospital or other medical facility admitted to or discharged from concerning this disease or condition, to include the dates: _____

_____

_____

_____

I hereby give permission to any physician, medical practitioner, hospital, medical facility, insurance or reinsurance companies to release, upon presentation of the original or a photocopy of this signed and dated authorization, requested information to **Windsor Life Insurance Company** or its representative (specifically the Claims Department, Medical Director, Legal Department, or Investigative Agency) in connection with any disease, treatment, prior medical history or prescription. This authorization includes information relating to medical illness, use of drugs, and use of alcohol. I understand that such information will be used by **Windsor Life Insurance Company** for the purpose of evaluation of my claim for insurance benefits, and I wish this authorization to be effective from the date signed for the duration of the claim.

Date_____ Signature of Insured _____

An Alliance in Growth

WINDSOR LIFE INSURANCE COMPANY

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Head Office

1345 River Bend Drive
Suite 100
Dallas, Texas 75247
U.S.A.
Tel.: 214 528-2020
Fax: 214 528-2777
www.optimumre.com

_____ _____
Name of insured (please print) Date of birth

I, _____, the above named individual or the legal representative of the above named individual/patient, hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to the above named insured or on their behalf within the past 10 years ("Providers") to disclose the entire medical record, prescription history, medications prescribed any other protected health information concerning the insured/patient to WINDSOR LIFE INSURANCE COMPANY. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Other Information:_____

This protected health information is to be disclosed under this Authorization so that WINDSOR LIFE INSURANCE COMPANY may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the insured has or has applied for with WINDSOR LIFE INSURANCE COMPANY.

This authorization shall remain in force for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of the Providers have already relied on the Authorization to disclose information about the insured or to the extent that WINDSOR LIFE INSURANCE COMPANY has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the recipient except as authorized by me or required by law.

I understand that if I refuse to sign this authorization to release the complete medical records of the insured/patient, WINDSOR LIFE INSURANCE COMPANY may not be able to process my claim, or may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or his/her Legal Representative Date

_____
Description of Legal Representative's Authority & Relationship to Insured/Patient