



## Authorization for Release of Health Information for Underwriting Purposes

**ADVANTAGE Health Solutions, Inc.**

I authorize that any/all health statements or health information forms that I have signed within the 90-day period prior to the date this form is signed can be released to ADVANTAGE Health Solutions, Inc. for the purpose of underwriting the group insurance benefits provided by the employer named below. I also authorize all of my health care providers and any insurance company or support organization to disclose to ADVANTAGE information or records related to my medical condition, medical or claim history, or disability or genetic information for use now or in the future for coverage or claim purposes. This authorization includes information about drug and alcohol use and psychiatric conditions.

I understand that if I refuse to provide this authorization, ADVANTAGE Health Solutions, Inc. may not make an underwriting determination, and I will not be considered for coverage with ADVANTAGE Health Solutions. I also understand that ADVANTAGE may need additional or updated information from me prior to issuing coverage; and that any material misstatement or omission in any of the information used or reviewed by ADVANTAGE may result in denial of claims or rescission of coverage.

I have read and I understand this authorization.

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

**A copy of this signed, completed authorization form is available to you upon request.**