

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-622-1993
&
STUDENT ATHLETIC PROTECTION, INC.
PO BOX 20239, Kalamazoo, MI 49019
1-800-232-1579

AUTHORIZATION
To Permit Use and Disclosure of Health Information

This authorization was prepared by GTL for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photo copy 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 Guarantee Trust Life Insurance Company (GTL) or Student Athletic Protection, Inc.(SAP), its 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 our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than me, that individual and my authority to act on their behalf are 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 GTL/SAP at either of the above addresses. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or in 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 Guarantee Trust Life Insurance Company/Student Athletic Protection, Inc. 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 GTL/SAP in accordance with federal or state law.

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

(Print Please) Name of Patient

Signature of Patient and Date

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

Relationship of Authorized Representative or Next of Kin to Patient

Signature of Authorized Representative or Next of Kin and Date