



P.O. Box 3211  
Milwaukee WI 53201-3211

414-273-6266 Telephone  
414-223-3201 Fax  
800-927-2547 Toll-Free  
catholicfinanciallife.org

For overnight delivery use 1100 West Wells Street, Milwaukee, WI 53233

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### Authorization to Obtain Medical Information

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**Insured:**

Insured's Name \_\_\_\_\_ List all names by which the insured may have been known, including maiden or  
hyphenated name or nickname, derivative form of first and or middle name or an alias.  
Insured's Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Social Security # \_\_\_\_\_

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**Medical Provider:**

1. Physician/Facility Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
2. Physician/Facility Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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I, the Insured, hereby request and authorize the Medical Provider (listed above) to give to **Catholic Financial Life**, its legal representatives or its records collection agent, any and all medical and non-medical information about me, and/or my minor child (only if the child is the insured) for the period starting on \_\_\_\_\_, to the present and up to two years beyond the date of this authorization.

I understand that the information to be disclosed may include diagnosis or medical history, treatment or prognosis of any physical, psychological, psychiatric and emotional illness, drug or alcohol abuse, communicable or venereal disease, Acquired Immune Deficiency Syndrome, HIV testing, Hepatitis A, B, C and sickle cell anemia.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> History and physical       | <input type="checkbox"/> Consultation reports | <input type="checkbox"/> Doctor/Clinic progress notes<br>(except psychotherapy notes) |
| <input type="checkbox"/> Hospital records           | <input type="checkbox"/> Discharge summary    | <input type="checkbox"/> Surgical reports   |
| <input type="checkbox"/> Laboratory & X-ray reports | <input type="checkbox"/> Pathology reports    | <input type="checkbox"/> Other _____  |

I understand that Catholic Financial Life will use this information to determine eligibility for benefits being applied for on the life insurance. Catholic Financial Life will only release this information to organizations performing business, insurance or legal services for Catholic Financial Life in connection with this application or claim, or as may otherwise be lawfully required. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) rule.

This authorization shall remain in effect for two years from the date shown below, unless revoked earlier. This consent may be revoked at any time upon written request executed by the undersigned and directed to Catholic Financial Life, 1100 W. Wells St., Milwaukee, Wis. 53233. Such revocation will have no effect on actions already taken by Catholic Financial Life or its authorized agents. Health care and payment of health care will not be affected if this authorization is not signed.

I agree that a photographic or faxed copy of this authorization shall be as valid as the original. I (or my authorized representative) have the right to refuse to sign this authorization. However, Catholic Financial Life may refuse coverage or payment of claimed benefits if this authorization is not signed. I (or my authorized representative) am entitled to receive a copy of this authorization form.

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Insured's Signature \_\_\_\_\_ Date \_\_\_\_\_  
*(Parent or guardian, if insured is under age 16, or authorized representative)*

Relationship to Insured *(if not signed by Insured)* \_\_\_\_\_

(Continued)

# Attending Physician's Statement

Your physician must complete this page at no expense to Catholic Financial Life.

1. Diagnosis and concurrent condition(s), include all Diagnosis Codes: \_\_\_\_\_
2. Is this condition caused by or related to patient's employment?  Yes  No

3. Report of services or attach itemized bill. If a previous form has been submitted, you only need to show dates and services since last report.

Date of Service	Place of Service	Description of Services	Code	Charges
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4. Date symptoms first appeared or accident happened. Date \_\_\_\_\_
5. Date patient first consulted you for this condition. Date \_\_\_\_\_
6. Has the patient ever had same or similar condition?  Yes  No  
If yes, list when and describe \_\_\_\_\_
7. Is the patient still under your care for this condition?  Yes  No
8. Name, address and phone of referring physician.  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
9. Period during which patient was continuously totally disabled. \_\_\_\_\_ To \_\_\_\_\_ From \_\_\_\_\_
10. Period during which the patient was partially disabled. To \_\_\_\_\_ From \_\_\_\_\_
11. If still disabled, what date do you expect the patient to return to work? Date \_\_\_\_\_
12. Period during which patient was house-confined. To \_\_\_\_\_ From \_\_\_\_\_
13. Does patient have other health coverage?  Yes  No  
If yes, please identify \_\_\_\_\_

**Insurance fraud may or may not be a crime subject to civil and criminal penalties.  
If you reside in a state listed below that fraud warning applies to you.  
I have read the fraud warning for my current state of residence.**

Physician's Name (*print*) \_\_\_\_\_ Degree \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Forward all claims to: Catholic Financial Life H & A Claims; 1100 W Wells St, Milwaukee WI 53233  
Contact the Claim Department if you have any questions at (414) 273-6266 or 1-800-927-2547.



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## State Fraud Warnings

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**Alaska:** Any person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

**Arizona:** For your protection Arizona state law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** For your protection Colorado law requires the following to appear on this form. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** Warning: It is a crime to provide false or misleading information to any insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Idaho:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

**Indiana:** Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

**Kentucky:** Any person who, knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

**Louisiana:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Maine:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

**Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**West Virginia:** Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.

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