

Re: Certificate No. _____
Insured Member: _____

Dear,

This letter authorizes a person/persons not covered under the above referenced Certificate to make coverage changes as well as obtain information concerning this coverage. This does not include canceling insurance coverage. The following must be signed by you and returned to our office.

AUTHORIZATION TO MAKE COVERAGE CHANGES

I, _____, am exercising my right under the HIPAA Privacy Regulations effective 4-15-03, to name my _____ (Relationship), _____ (Name), as my Individual Personal Representative. By naming him/her as such, I _____ am authorizing The Chesapeake Life Insurance Co in North Richland Hills, Texas, to release benefit information, claim status, payment or denial information and further authorize _____ to make changes to coverage.

The information may be released/changed on the following person/persons covered under my Certificate/Policy:

Please maintain this letter in my records. This authorization will remain in effect unless notified by me in writing.

Signature of Insured

Date

We appreciate your attention to this matter. If you have any questions, please contact our Customer Care Center at (800) 733-1110, or you can fax your inquiry to (888) 377-4391.

Sincerely,

The Chesapeake Life Insurance Co
Customer Care Center
J863/SLTR

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