



# STERLING MEDICARE SUPPLEMENT<sup>SM</sup>

Underwritten by Sterling Life Insurance Company

If you would like to receive information on additional products and services, you have the option to read, sign and return this Authorization form. We look forward to being able to keep you up to date with the latest products available through Sterling.

## Authorization for Use and Disclosure of Your Protected Health Information

### Authorization To Use Protected Health Information:

I authorize Sterling Life Insurance Company ("Sterling") to use my name, address and telephone number ("Protected Health Information") to contact me or my family regarding products and/or programs offered or provided by Sterling or through an insurer with whom Sterling or a subsidiary of Sterling has a contract to sell their products. I authorize Sterling to provide this contact information to licensed and appointed sales agents of Sterling or Sterling's subsidiary who need to know this information to contact me. Sterling will be paid a fee by the affiliated insurer for the sale of any product. I understand and agree that my Protected Health Information may and will only be used and disclosed as described herein.

### Important Information About your Rights:

- I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my treatment, payment for my health care services, health plan enrollment or benefits.
- I understand that any Protected Health Information disclosed pursuant to this Authorization to a third party that is not covered by state or federal privacy law may be subject to redisclosure by the recipient and no longer protected by federal or state law.
- I understand that I may revoke this Authorization at any time by submitting my written request for revocation to Sterling Life Insurance Company, 2219 Rimland Drive Bellingham, WA 98226, Attention: Privacy Officer and that my revocation will be effective immediately upon receipt. However, I understand that my revocation will not be effective to the extent that Sterling or a third party has taken action in reliance on this Authorization for a use or disclosure of my Protected Health Information prior to receiving my revocation.
- I understand that this Authorization will be effective until 60 days following the date I am no longer a policyholder under any policy offered or provided by Sterling Life Insurance Company.

**By signing this Authorization for Release of my Protected Health Information, I understand and agree to the statements contained herein and authorize the use and disclosure of my protected health information as described above.**

*Enrollee Signature*

*Today's Date*

*Enrollee's Representative Signature*

*Today's Date*

Relationship to the individual

**A copy of this authorization must be provided to the individual or the individual's representative.**