The **Federal** Long Term Care Insurance Program™

Medical Release

Insured's name

First name | M.I. | Last name

Date of birth Month / Day / Year

For claims-related purposes of the Federal Long Term Care Insurance Program, including determining eligibility for benefits, care coordination, claims decision-making, coordinating benefits with other insurance companies or payers, claims payment, claims appeals, and claims management activities, I authorize any licensed health care practitioner, medical facility, employer, insurance company, or any other entity or person that has any health information about me to give that health information to Long Term Care Partners (LTCP), LLC, John Hancock Life & Health Insurance Company (John Hancock), their reinsurers, and their subcontractors who need to know health information to provide contracted services.

The health information I am permitting to be disclosed and used for the Federal Long Term Care Insurance Program includes any information on my medical history, and the diagnosis, prognosis, and treatment of any physical or mental condition, whether such history is in electronic or paper form. It includes the disclosure of any medical care or surgery, psychiatric or psychological care or examinations, and information about alcohol or drug use (including any information otherwise protected by Federal Regulations 42 CFR Part 2 or other applicable laws). I understand that this authorization includes my consent to use and disclose medical information that relates to mental illness, HIV, AIDS, HIV-related illness, and sexually transmitted diseases or other serious communicable diseases, but only in accordance with any law or regulation that applies to any such disclosure of this information about me.

I understand that:

- If I do not sign this authorization, any claim for long term care insurance benefits may be denied.
- I may revoke this authorization at any time, except to the extent that action has already been taken in reliance on it before my revocation.
- To revoke this authorization, I must notify **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797** in writing.
- If I do revoke this authorization, I understand that my application for long term care insurance may not be processed and any claim for long term care insurance benefits may be denied. LTCP or John Hancock has a right to contest my long term care insurance claim or coverage.
- If I do not revoke this authorization, it will be valid until the coverage terminates.
- My health information may be redisclosed and no longer protected by applicable law, including federal health information privacy regulations. This can occur only if such redisclosure is required or allowed by law (e.g., in response to a subpoena).
- A copy of this authorization is as valid as the original.

Insured's signature _____ (Required) **Date signed** ____ / ____ / ____ (Required: mm/dd/yy)

If the insured is unable to sign for him- or herself, please include a copy of the durable financial power of attorney or guardianship papers, if not already submitted.

Legal representative's signature _____ (Required) **Date signed** ____ / ____ / ____ (Required: mm/dd/yy)

Note: Handwritten signatures are required.

Please return your completed form by fax to **1-866-513-2674** or by mail to **Long Term Care Partners, LLC, P.O. Box 797, Greenland, NH 03840-0797**.

The Federal Long Term Care Insurance Program is sponsored by the U.S. Office of Personnel Management, insured by John Hancock Life & Health Insurance Company, and administered by Long Term Care Partners, LLC.

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