

FAILURE TO PROVIDE ALL INFORMATION REQUESTED IN THIS FORM AND SIGNED MEDICAL AUTHORITY MAY CAUSE EXTREME DELAYS IN PROCESSING YOUR CLAIM.

Please ensure that this completed form is returned promptly to **Claims at TuGo** with signed Medical Authority.

MEDICAL AUTHORITY

Authorization to physicians, hospitals, other medical providers & other insurers

1. I authorize all hospitals, physicians, medical care providers, insurers and other persons, from all countries, to provide to **Claims at TuGo** all information and documentation in their possession that **Claims at TuGo** requires to process my claim, including: records in regard to illnesses, injuries, medical history, consultations, medicines and treatments of the claimant named below (collectively, the "Medical Records") and other applicable insurance policy information.
2. I authorize **Claims at TuGo** to collect, use and disclose the Medical Records, and the information in the Medical Records, to the selling agent, and to any insurers, including government health plans, that may have a responsibility in this claim.
3. I understand that the purpose for the collection, use and disclosure of the Medical Records and other insurance policy information is to enable **Claims at TuGo** and insurers to assess and determine the eligibility of and other available insurance for any claim I might submit. I acknowledge and agree that it is my responsibility to provide to **Claims at TuGo** such information and other documentation as may reasonably be required to process my claim and that my failure to do so will jeopardize my entitlement to coverage.
4. I understand that if Medical Records are required from the U.S., this purpose constitutes a payment operation under the privacy rules in the U.S. Health Insurance Portability and Accountability Act.
5. This authorization takes effect on the date set out below. I understand that I may revoke this authorization in writing. I acknowledge and agree that if this authorization is revoked before the Medical Records are collected and reviewed my entitlement to insurance coverage will be jeopardized.

A copy of this authorization received from **Claims at TuGo** shall be as effective and valid as the original.

FIRST NAME _____ LAST NAME _____

Print name (and relationship if not claimant)

X _____

Signature (Claimant or authorized representative)

MM | DD | YYYY _____

Date