



An Independent Licensee
of the Blue Cross and
Blue Shield Association

Disclosure Authorization Form

(To authorize BCBSAZ to disclose your information to CSA Marketing Resources, Inc.
in connection with your life insurance application)

Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

By signing this form, you authorize BCBSAZ to disclose the information contained in your BCBSAZ Individual Application and your BCBSAZ subscriber identification number, if any, to CSA Marketing Resources, Inc., an entity which performs administration on behalf of life insurance carriers. The purpose of the disclosure is to allow both CSA Marketing Resources, Inc. and BCBSAZ to perform administrative services in connection with any life insurance you may receive as a result of completing and submitting the Individual Application.

This authorization will expire upon the termination of your policy with BCBSAZ or, if you do not obtain a policy with BCBSAZ, within six (6) months from the date set forth below. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws.

You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, C105, BCBSAZ, P.O. Box 13466, Phoenix, AZ 85002-3466. Your revocation will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.

Those individuals 18 years or older should sign and complete the information below.

_____ Printed Name	_____ Social Security Number
_____ Signature	_____ Date
_____ Printed Name	_____ Social Security Number
_____ Signature	_____ Date
_____ Printed Name	_____ Social Security Number
_____ Signature	_____ Date
_____ Printed Name	_____ Social Security Number
_____ Signature	_____ Date
_____ Personal Representative's (PR) Name	_____ PR's Relationship to Individual
_____ Signature	_____ Date

**You are entitled to a copy of this authorization after you sign it.
You may refuse to sign this authorization.**