iSured

Michael David

e-Sign Activity

DOCUMENTS

- New
- Inbox
- Sent
- Drafts
- Deleted

TEMPLATES

REPORTS

SIGNERS

Sort/View

Filter By

Document Set Name 1
Status
Type
Organization
Signing Type

Created: 11/28/2016 12:03 pm EST
Last updated: 7/9/2017 12:03 pm EST

Correct Resend Cancel

Document Set Name 2
Status
Carrier
Distributor/Organization
Review Type

Created: 11/28/2016 12:03 pm EST
Last updated: 7/9/2017 12:03 pm EST

Resend Cancel

Edit
Copy
Move
Delete

Document Set Name 3
Status
Type
Organization
Signing Type

Created: 11/28/2016 12:03 pm EST
Last updated: 7/9/2017 12:03 pm EST

Resend Cancel

Document Set Name 4
Status
Type
Organization
Signing Type

Created: 11/28/2016 12:03 pm EST
Last updated: 7/9/2017 12:03 pm EST

Resend Cancel

Document Set Name 5
Status
Type
Organization
Signing Type

Created: 11/28/2016 12:03 pm EST
Last updated: 7/9/2017 12:03 pm EST

Resend Cancel

‹ 1 2 3 4 5 ›

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Michael David

e-Sign Activity

BACK TO MY DASH

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Michael David

Info

Details | Details

Help Save Select Signer

Show Alerts

BACK

- Document Set
- eSign Recipients
- Design
- Signing Order
- Authentication

Design - Authorization for Release of Information

The Lincoln National Life Insurance Company ("Company")
PO Box 2348, Fort Wayne, IN 46801-2348
Home Office Location:1300 S Clinton St.
Fort Wayne, IN 46802-3506

AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient ____________________ Date of Birth ____________

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities) or if other, indicate here: ____________________
to give all such information to The Lincoln National Life Insurance Company (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: ____________________

____

I understand that an authorization for release or disclosure of ps
or disclosure of any other information (a separate authorizatio

I understand that the information obtained may be used by the Co
The Company may not give the information to any person or
may apply; 2) MIB; or 3) any other person or entity who per
my insurance coverage. I understand that some of these people
that the information they receive may be redisclosed, howeve
disclose to them. Information may be disclosed as allowed by

I understand this consent may be revoked in writing at any tim
Authorization; or 2) the Company is using this Authorization i
If written revocation is not received, this Authorization will be
in Kansas) from the date of signing. To initiate revocation of th

I understand that if I refuse to sign this Authorization to releas
my application.

Required Yes No

Label

Tooltip

Auto Place Yes No

Permissions

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

SIGNATURE: DATE: ____________
Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient: ____________

Add Control

- Signature Box
- Signature Initials
- Text Box
- Check Box
- Calendar
- Radio Button
- Dropdown List
- Label
- Barcode
- Button
- Data Grid

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Document Set
eSign Recipients
Design
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Authentication

Help Save Show Alerts

New Document Set

Authorization for Release of Information

Authorization for rel...

Add Document

Next

iSured

Michael David

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Help Save Show Alerts

Add Recipients

Name (s)

Contacts List

Role

Email

e-Signature Required

Advanced

Add Recipient

Go Back Next

iSured Start John Smith

The Lincoln National Life Insurance Company ("Company)
PO Box 2348, Fort Wayne, IN 46801-2348
Home Office Location:1300 S Clinton St.
Fort Wayne, IN 46802-3506

AUTHORIZATION FOR RELEASE OF INFORMATION

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient ______________________________ Date of Birth ______________

or the proposed insured's health, including but not limited to transaction records, employment records, financial records, and complete medical records (including information regarding insurance, demographics, referral documents and records from other facilities) or if other, indicate here: ______________________________

to give all such information to The Lincoln National Life Insurance Company (the Company), their licensed representatives and/or their reinsurers, MediConnect.net Inc, GiS, or if other, indicate here: ______________________________

______________________________.

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate authorization must be completed for release or disclosure of psychotherapy notes).

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the administration of my insurance coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months (12 months in Kansas) from the date of signing. To initiate revocation of this Authorization direct all correspondence to the address above.

I understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application.

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

SIGNATURE: Sign ______________________________ DATE: Date ______________

Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient: ______________

iSured

John Smith

Adopt Signature

Full Name

John Smith

Initials

JS

Select Styling | Draw Signature

Preview

John Smith | JS

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen and paper signature or initial.

Go Back

Adopt and Sign

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient:____________________

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.
AN10041

Mail ●●●●○ LTE 3:25 PM 58%

FireLight e-Sign

Adopt Signature

Full Name

John Smith

Initials

JS

Select Styling | Draw Signature

Preview

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen and paper signature or initial.

Go Back

Adopt and Sign