**Authorization to Release Information**

**I hereby authorize representatives/employees of the Indiana Department of**

**Insurance (“Department”)** to discuss my complaint and my insurance policies and/or annuity

contracts with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name of your chosen representative in this matter

I am aware the information disclosed may include, but is not limited to, policy terms, policy values, named insureds, policy beneficiaries, health information, and/or financial information. I understand any changes made to the policies or contracts will require prior authorization by me. I wish to restrict the authorization to release information to the policies or contracts listed below:

Policy/Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy/Contract #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return the completed form to:

Indiana Department of Insurance

Consumer Services Division

311 W. Washington Street, Ste. 103

Indianapolis, IN 46204

Questions: (317) 232-2395 or (800) 622-4461