

The Prudential Insurance Company of America
administered by illumifin Corporation (DBA in California: illumifin Administration)
ATTN: Health Services Division
PO Box 64372
St Paul, MN 55164-0372

AUTHORIZATION
FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act (HIPAA), The Prudential Insurance Company of America as administered by illumifin Corporation (DBA in California: illumifin Administration) may not use or disclose your health information except as provided in our Privacy Notice of Insurance Information Practices. Your signature on this form indicates that you are giving permission for certain use or disclosure of your health information.

I authorize the use or disclosure of my individually identifiable health information as indicated below by illumifin Corporation (DBA in California: illumifin Administration) to the following individual or entity (include name, address, and relationship):

The specific health information to be used or disclosed:

- _____ Claim Payment Information
- _____ Application/Enrollment Information
- _____ Health Premium Payment Information
- _____ Medical Records
- _____ Other _____

Reason or purpose of providing the health information to the individual/entity named above:

I understand this authorization will expire 24 months from the date the authorization is signed. I also understand that I may revoke this authorization at any time by providing illumifin Corporation with written notice of revocation. If I do revoke this authorization, it will not have any affect on any information released before illumifin Corporation's receipt of the revocation, including any action taken by the individual/entity that received the health information. Health information used or disclosed as instructed by this authorization may be further disclosed by the individual/entity receiving the health information and, therefore, no longer protected by the HIPAA privacy law.

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain insurance or eligibility for benefits will not depend in any way on whether I sign this authorization.

Signature of Individual who is the subject of the Health information

Date

Print Name of Individual who is the subject of the Health information

Policy Number

Submit the completed form to:

The Prudential Insurance Company of America
as administered by illumifin Corporation (DBA in California: illumifin Administration)
ATTN: Compliance Support Services ✦ Post Office Box 64372, St Paul, MN 55164-0372

Note: If this authorization is signed by an authorized representative of the individual, provide a brief description of the representative's authority to act for the individual and attach supporting documentation (e.g. Power of Attorney, Estate Documentation) _____

Signature of Authorized Representative: _____