**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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