

# Authorization for Release Medical Information



Zurich American Life Insurance Company  
7045 College Boulevard  
Overland Park, KS 66211-1523

The purpose of this authorization is to allow us to provide you or your physician with private health information we have gathered during our underwriting consideration.

I authorize the release of my medical information (including any or all of the following: oral fluid, blood or urine tests, nicotine tests, illicit drug tests, medical/paramedical examination, electrocardiogram) completed as part of my life insurance application. Please process request and send records to:

**(Please include street addresses only, confidential records mailed Fed Ex)**

Personal home\* address at: (No PO boxes please)

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Primary care physician/medical facility at: (No PO boxes please)

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Name of Proposed Insured (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature Proposed Insured

\_\_\_\_\_  
Date

This authorization is valid for 6 months from the date signed by the proposed insured.

\* California restricts the release of mental health information – it can only be released to the designated physician.