tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

ASSIGNMENT OF BENEFITS

Policyholder Name _____ Policy #_____

I, _____ *(print Policyholder's name)*, authorize and request Penn Treaty Network America Insurance Company (Penn Treaty Network America Life Insurance Company in California), and/or American Network Insurance Company (individually and collectively referred to as "Penn Treaty") to pay directly to the service provider named below (the "Provider"), any amount(s) due me under the above-referenced insurance policy(ies) (the "Policy(ies)") as a result of care or services rendered or provided to or for me by the Provider (the "Assignment"). I understand that benefits due, if any, will be paid in accordance with and subject to all terms and conditions of said Policy(ies).

Service Provider Information

This section MUST be fully completed – Please get this information from your service provider.

Service Provider's Name	Service Provider's Address & Telephone Number	Service Provider's Tax Identification Number

I understand that this Assignment shall be effective as of the date I sign this form but it will apply only to those amount(s) due me under the Policy(ies) that have not yet been paid by Penn Treaty as of the date Penn Treaty receives and processes this Assignment, regardless of the dates of service involved. I further understand that any payment made by Penn Treaty to the Provider in accordance with this Assignment does not relieve me of my payment obligation(s) to the Provider, nor does this Assignment create any contractual relationship between Penn Treaty and the Provider. I understand that I am solely responsible for the payment of the Provider's charges and that I may receive amount(s) due me under the Policy(ies) even after my execution of this Assignment. I agree to indemnify and hold Penn Treaty harmless for any amounts paid directly to me under the Policy(ies) following Penn Treaty's receipt of this Assignment. I further understand that the Provider's charges may exceed the amount(s) due me under the Policy(ies) and that I am solely responsible to the Provider for such excess charges.

(continued on reverse)

Policyholder: _____
Policy number: _____

This Assignment may be revoked by me or my legal representative by sending written notice to Penn Treaty, ATTN Claims Department, PO Box 7066, Allentown, PA 18105-7066. Such revocation shall be effective only after its receipt has been recorded by Penn Treaty, and shall apply only to payments issued after the revocation effective date, regardless of the date(s) on which covered care or services were rendered or provided, or the charges thereof were incurred.

_____ _____
Signature of Policyholder Date
or Policyholder's personal/legal representative*

NOTE: Please remind your service provider to complete Form W-9 and return it to Penn Treaty.

The service provider must sign below:

I accept the direct assignment of benefits and understand that I may receive a Form 1099 from Penn Treaty.

_____ _____
Service Provider's Signature Date

***If this Assignment is signed by Policyholder's personal/legal representative, please complete the following and attach copy of legal document if not already on file.**

Personal/legal representative name _____

Relationship to policyholder _____

Basis for representation (check one):
❑ Power of Attorney ❑ Guardian ❑ Other: _____

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER

To be completed by the care provider when accepting Assignment of Benefits.

Please complete and return to:

Penn Treaty
PO Box 7066
Allentown PA 18105-7066

Policyholder _____

Policy # _____

STEP 1. *(Check ONE box only and provide your complete name and Taxpayer Identification Number.)*

☐ **U.S. Resident - Individual / Sole Proprietor** (Form 1099 reportable)

Name _____

If you are a sole proprietor, name of the owner of the business: _____

Social Security Number __ __ __ – __ __ – __ __ __ __ ***or*** Employer Identification Number __ __ – __ __ __ __ __ __ __

☐ **U.S. Partnership, Limited Liability Company ("LLC"), or Trust** (Form 1099 reportable)

Name (as shown on your tax return) _____ Employer Identification Number __ __ – __ __ __ __ __ __ __

_____

☐ **U.S. Corporation** (exempt from Form 1099 reporting except for medical or legal services)

(If an LLC electing corporate status for U.S. tax purposes, please attach a copy of your U.S. tax election on IRS Form 8832, *Entity Classification Election*)

Name (as shown on your tax return) _____ Employer Identification Number __ __ – __ __ __ __ __ __ __

_____

☐ **U.S. Tax-Exempt Organization or Federal, State, or Local Government Agency** (exempt from Form 1099 reporting)

Name (as shown on your tax forms) _____ Employer Identification Number __ __ – __ __ __ __ __ __ __

_____

STEP 2. Certification/Signature (*Complete the following*) Under penalties of perjury my signature certifies that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.
3. I am a U.S. person (including a U.S. resident alien).

Certification Instructions: You must cross out item 2 above if you have been notified by IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, number 2 above does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.

Signature: _____ Phone: ( ) _____

Print Name: _____ Title: _____ Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Instructions for U.S. Tax Persons

As a business, federal income tax law requires us to report certain payments we make to you if you are not exempted from this reporting responsibility. In order for us to properly meet the federal tax law requirements, we need certain information from you. Please complete the information requested above and return this form to the address shown above. If you do not provide us with your correct taxpayer identification number, you may be subject to a $50 penalty imposed by the Internal Revenue Service. In addition, you may be subject to 28% backup withholding on reportable payments we make to you. *If you have any questions, please call us at* _____ _____ *(provide requester's telephone number).*

Are you a U.S. person? The IRS defines a U.S. person as:

- a U.S. citizen;
- an entity (company, corporation, trust, partnership, estate, etc.) created or organized in, or under the laws of, the United States; a state; or the District of Columbia
- a U.S. resident (someone who has a "green card" or has passed the IRS "substantial-presence test." For an explanation of the substantial-presence test, please see IRS Pub. 515 or 519, available at *www.irs.gov*.)

If your answer is NO, please do not complete this form and contact us at *(insert requester's phone number here)* _____.
If your answer is YES, please complete the form. See page 2 for additional information.

Instructions for Non-U.S. Persons

If you are a non-U.S. resident or a corporation, partnership or other entity formed outside the U.S. and you are receiving payments as beneficial owner, IRS procedures require you to submit one of the following forms for use in determining the correct course of tax withholding on and information reporting of payments made to you.

These forms are available at www.irs.gov.

- IRS Form 8233, *Exemption From Withholding on Compensation for Independent (and Certain Dependent) Personal Services of a Nonresident Alien Individual* **OR**
- IRS Form W-8 ECI, *Certificate of Foreign Person's Claim for Exemption from Withholding on Income Effectively Connected with the Conduct of a Trade or Business in the United States,* **OR**
- IRS Form W-8 BEN, *Certification of Foreign Status of Beneficial Owner for United states Tax Withholding.*

If you are not a beneficial owner, but instead acting in an agency capacity for a beneficial owner, you may be required to submit:

- IRS Form W-8IMY, *Certificate or Foreign Intermediary, Foreign Flow-Through Entity, or Certain U.S. Branches for United States Tax Withholding.*

If you need assistance in completing one of the above forms, please consult your U.S. tax advisor for the appropriate help in determining which of these forms should be submitted and in correct completion of the form. We require your provision of this information to assist us for tax purposes in correctly withholding and reporting payments we make to you for your services.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered on the form.

Sole proprietor. Enter your individual name as shown on your income tax return. You may also enter your business, trade, or "doing business as (DBA)" name.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name and the LLC's name on the form.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner, enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 of the instructions for the IRS Form W-9, available at *www.irs.gov,* for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required, or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions for the IRS Form W-9, available at *www.irs.gov,* under "Exempt from Backup Withholding" for more information.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

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ATTENDING PHYSICIAN'S STATEMENT

Prompt completion of this form in its entirety will expedite our evaluation of your patient's claim.
Fees for completing this form are not covered by the insurance and are the patient's responsibility.

Patient name _____ Policy # _____ DOB _____ / _____ / _____

1. Are you this patient's PCP? ❑ yes ❑ no *If no, indicate your specialty* _____

2. Was this patient referred to another physician, specialist, or surgeon? ❑ yes ❑ no *If yes, please provide:*

Name _____ Telephone (____) _____ Specialty _____

3. Date you last saw this patient ____ / ____ / ____ Reason for visit _____

4. Diagnoses (or ICD-9 codes) necessitating need for care and dates of onset _____

_____

5. Activity restrictions? ❑ yes ❑ no *If yes, list restrictions* _____

6. Level of care: Home Care (select one): ❑ HHA/Personal Care ❑ Homemaker
❑ Nursing home
❑ Assisted living facility
❑ Personal residence
❑ Adult day care
❑ Other _____

7. Expected duration of care _____ days or _____ weeks

For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Please refer to the accompanying page for mandated state-specific fraud language.

x_____ _____ / _____ / _____
Physician signature Date

Physician name _____ Telephone (____) _____

Street _____ Fax (____) _____

City_____ State_____ Zip_____

FRAUD STATEMENT

For your protection, certain states require specific mandated fraud language to be included on all claim forms. Other states permit the use of a more generalized fraud statement.

California
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maryland
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon
Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

All Other States Not Listed Above

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim for payment of a loss or benefit containing any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be prosecuted under state law. Penalties may include imprisonment, fines, denial of insurance or insurance benefits, and civil damages. Insurance fraud is considered a felony offense in Delaware, Florida (third degree), Idaho, Indiana and Oklahoma.

FRAUD STATEMENT

For your protection, certain states require specific mandated fraud language to be included on all claim forms. Other states permit the use of a more generalized fraud statement.

California
For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maryland
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey
Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon
Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

All Other States Not Listed Above

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim for payment of a loss or benefit containing any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be prosecuted under state law. Penalties may include imprisonment, fines, denial of insurance or insurance benefits, and civil damages. Insurance fraud is considered a felony offense in Delaware, Florida (third degree), Idaho, Indiana and Oklahoma.

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FACILITY CERTIFICATION OF CARE FOR INITIAL CLAIM

Please print clearly using blue or black ink

Resident Identification

Name _____ Policy # _____ DOB _____ /_____ /_____

Part 1: Facility Instructions *Please complete this form and attach the following information:*

- ❑ All facility health interviews or nursing assessments
- ❑ Copy of all state licenses held by the facility
- ❑ Resident's agreement (applies to assisted living facility)
- ❑ Itemized bill
- ❑ Medicare EOB's (if applicable)

This form must be completed in full by the Director of Nursing/Charge Nurse.
A benefit determination cannot be made until we receive all information requested.
Please be sure to sign and date this form below. You may fax all forms to 610-965-6962.

Part 2: Facility Eligibility Information

1. Facility name _____

2. Street _____

   City_____ State_____ Zip_____

3. Telephone (___) _____ Fax (___) _____ E-mail _____

4. Taxpayer identification # ___ ___ - ___ ___ ___ ___ ___ ___ ___

5. Facility type: ❑ nursing ❑ assisted living ❑ independent living ❑ personal care
   ❑ continuing care and residential community ❑ other (explain) _____

6. Level(s) of care (check all that are available): ❑ skilled ❑ intermediate ❑ custodial
   ❑ assisted living ❑ secured unit ❑ independent

7. Maintain medical and care records? ❑ yes ❑ no 8. Number of beds _____

(continued)

Name _____ Policy # _____ DOB _____ /_____ /_____

All questions must be answered for the resident to be considered for benefits.

Part 3: Resident Information

1. Initial admission date ____ / ____ / ____ Admitted from: ❑ residence ❑ hospital ❑ other _____
2. Discharge date ____ / ____ / ____ Discharged to: ❑ residence ❑ hospital ❑ other _____

3. Any out-of-facility dates? ❑ no ❑ yes *If yes, complete the following:*

left ____ / ____ / ____ returned ____ / ____ / ____ ❑ to hospital ❑ other _____
left ____ / ____ / ____ returned ____ / ____ / ____ ❑ to hospital ❑ other _____

4. Bed hold charges? ❑ yes ❑ no If yes, amount charged per day $ _____

5. Admitting diagnosis _____

6. Current diagnosis _____

7. Admitting physician name _____ Telephone (____) _____

Street _____

City_____ State_____ Zip_____

8. Is the stay Medicare approved? ❑ no ❑ yes
If yes, list dates paid in full ____ / ____ / ____ through ____ / ____ / ____
List co-pay dates ____ / ____ / ____ through ____ / ____ / ____

9. Resident's care level: *check all that apply including the "From" and "To" dates*

	From	**To**	**From**	**To**
❑ **Skilled**				
❑ **Intermediate**				
❑ **Assisted Living**				
❑ **Independent Living**				
❑ **Retirement Community**				
❑ **Other (explain)**				

For your protection, state insurance laws require the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. Please refer to the accompanying page for mandated state-specific fraud language.

11. Print name _____ Title_____

Signature _____ Date _____ /_____ / _____

PENN TREATY

FRAUD STATEMENT

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For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maryland
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Oregon
Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

All Other States Not Listed Above

WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim for payment of a loss or benefit containing any false, incomplete or misleading information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act and may be prosecuted under state law. Penalties may include imprisonment, fines, denial of insurance or insurance benefits, and civil damages. Insurance fraud is considered a felony offense in Delaware, Florida (third degree), Idaho, Indiana and Oklahoma.

PENN TREATY

tel 800.362.0700
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HIPAA COMPLIANT AUTHORIZATION TO RELEASE INFORMATION

Authorization: I authorize and direct any physician, medical practitioner, hospital, clinic, care provider, other medical or medically related facility; residential, residential care, or residential treatment facility, social service organization, insurance support organization, insurance company, reinsurance company, benefit plan administrator, pharmacy, attorney, consumer reporting agency, employer, state or federal government agency including the Social Security Administration, or other entity having information about me to release to Penn Treaty Network America Insurance Company (Penn Treaty Network America Life Insurance Company in CA), hereinafter referred to as "Penn Treaty," or its agents or representatives, any and all information they possess concerning my medical care, treatment or advice including medical or other care records, diagnosis, pharmacy information including information about drug or alcohol abuse, HIV, AIDS, mental and/or nervous conditions (except psychotherapy notes), and other non-medical information as deemed necessary by Penn Treaty to underwrite an insurance policy or determine my eligibility for benefits, including information I directed be withheld.

Revocation: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to Penn Treaty at 3440 Lehigh Street, Allentown, PA 18103 and will become effective when received by Penn Treaty. I understand that if I refuse to sign this authorization, or if I revoke this authorization, Penn Treaty may not be able to issue a policy to me and/or may be unable to determine my eligibility for benefits under a policy that is issued. I understand that even if I revoke this authorization, Penn Treaty will, and will be permitted to, obtain and disclose information as required or permitted by law and in accordance with its notices of information practices.

Disclosure and Redisclosure: Penn Treaty will only disclose or re-disclose information as required or permitted by law and in accordance with its notice of information practices.

Period of Validity: This authorization shall be valid; for underwriting - from the date signed for twelve (12) months; for claims - from the date signed for either twelve (12) months or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Copy Received: I, the undersigned, acknowledge that I have received a copy of this authorization.

Signature _____ Date _____

Applicant or policyholder name _____ Policy number _____
(PLEASE PRINT)

If this Authorization is signed by a personal or legal representative of the applicant or insured, please complete the following:

Personal/legal representative's name _____

Relationship to applicant/insured _____

Basis for representation (POA, Guardian, etc.) _____
(PLEASE ATTACH COPY OF LEGAL DOCUMENT)

PENN TREATY

tel 800.362.0700
fax 610.965.6962
www.penntreaty.com

POLICYHOLDER AUTHORIZATION TO RELEASE INFORMATION

Policyholder name _____ Policy number _____
PLEASE PRINT

AUTHORIZATION: I authorize Penn Treaty Network America Insurance Company, hereinafter referred to as "Penn Treaty," to release written and/or verbal information about my insurance policy and claim, including my medical care and treatment and other non-medical information as deemed necessary by Penn Treaty, to the following individuals:

Name (please print)	Relationship	Telephone number

REVOCATION: I understand that I have the right to revoke this authorization. Such revocation must be sent in writing to Penn Treaty at 3440 Lehigh Street, Allentown, PA 18103 and will become effective when received by Penn Treaty. I understand that even if I revoke this authorization, Penn Treaty will, and will be permitted to disclose information as required or permitted by law and as permitted by other authorizations I have given Penn Treaty, and in accordance with its notices of information practices.

DISCLOSURE AND REDISCLOSURE: Penn Treaty cannot guarantee that the individuals I have authorized will not disclose or re-disclose my personal information. If disclosed under this authorization, protected health information is no longer protected by the Health Insurance Portability and Accountability Act (HIPAA) and state and federal laws.

PERIOD OF VALIDITY: This authorization shall be valid from the date signed for either six (6) months, or as long as my policy remains in force, whichever is later, unless revoked by me or my legal representative. A photocopy of this authorization shall be considered as valid as the original.

Signed _____ Date _____

Name (please print) _____

If this authorization is signed by a personal or legal representative of the applicant/insured, complete the following:

Personal/legal representative's name _____

Relationship to applicant/insured _____

Basis for representation (POA, guardian, etc.) _____
PLEASE ATTACH COPY OF LEGAL DOCUMENT