

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 and named insureds or beneficiaries. Other information disclosed may also include health information and 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: _____

Dated: _____

Signature: _____

Printed: _____

Phone #: _____

Address: _____

Return the completed form to:

Indiana Department of Insurance
311 W. Washington Street, Ste. 300
Indianapolis, IN 46204