

AUTHORIZATION & ACKNOWLEDGEMENT

Insurance Company Name: _____ _____ _____	Insured Information Name: _____ _____ Certificate # _____ Date of Birth: _____
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I AUTHORIZE MCIS Multichoice Insurance Services, LLC to be directed all correspondence, inquiries and updates on my behalf.

I UNDERSTAND the purpose of this Authorization is to allow MCIS Multichoice Insurance Services, LLC to help me in this claim. Any information obtained will not be released by them, to any person or organization EXCEPT insurance company, or other persons or organization performing business or legal services in connection with my policy, claim or as may be otherwise lawfully required or as I may further authorize.

I AGREE that a photostatic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for 12 months from date shown below.

Date: _____

Insured Signature or Parent: _____

(Parent, if insured is minor)