CLAIM NUMBER:

MEDICAL RECORDS RELEASE AUTHORIZATION

In order for your claim to be fully evaluated for purposes of determining your eligibility for the receipt of benefits, you must sign the following authorization. Please note that the amount and type of medical information sought pursuant to this authorization will depend upon the nature of the claim, but that it will be used solely to facilitate determinations regarding the validity of the claim, the payment of benefits or the administration of the insurance prop under which the claim has been made. Your acceptance of benefits shall be considered an acceptance of the term in this medical authorization, unless you indicate to the contrary in writing.

Your decision not to authorize the release of any of the information described in this document does not eliminate your right that the PMA Companies or any other entity may have, under state and federal law, to obtain or disclose the information without an authorization. The authorization is subject to your revocation at any time except to the extent that any party has already acted in reliance upon it. Any revocation must be submitted in writing to The PMA Companies, P.O. Box 5231, Janesville, Wisconsin, 53547-5231, otherwise this authorization will continue to be valid.

Authorization to Release Medical Information

I hereby authorize any employer, insurance company, government agency, medical prepayment plan, or service organization, and any physician, surgeon, therapist, pharmacist, or other duly licensed practitioner of the healing arts and any hospital, including the Veteran's Administration, or medical transportation company, to release to any of the PMA Insurance group of companies (including the PMA Insurance Group, PMA Management Corporation and PMA Management Corporation of New England), and their subsidiaries, affiliates, representatives and agents (collectively, PMA Companies), any and all applicable medical records, medical information and benefit payment information with respect to any illness, injury, medical history, consultations, prescriptions, treatment or benefits, and copies of all applicable records thereof, which may be appropriate or necessary to establish the validity of this claim.

This authorization shall specifically include but shall not be limited to medical records, medical information and benefit payment information pertaining or relating to the treatment of AIDS, HIV, mental illness, and drug or alcohol related medical problems, I also authorize the Social Security Administration to release to PMA information concerning entitlement dates and benefit amounts for myself.

I further authorize The PMA Companies to release any such medical information to its reinsurers, attorneys or to medical peer review panels, state insurance or fraud agencies, managed care vendors, industry anti-bud or law enforcement organizations, research and statistical reporting organizations, or my employer and its excess insurer, to the extent that The PMA Companies considers doing so to be reasonably appropriate or necessary for purposes of its administration of the claim or the insurance program under which the claim has been made. I understand the information released to PMA as a result of this authorization may no longer be subject to certain protections provided under the Health Insurance Portability and Accountability Act of 1996.

Unless revoked earlier by me in writing this authorization shall be valid for twenty-four (24) months from the date listed below. A copy of this authorization is to be considered as valid as the original.

Signature _____ Date _____

Name: