Claim #: _____

AUTHORIZATION TO PROVIDE INFORMATION

I, _____ , authorize:

1. Any medical, osteopathic or chiropractic physician, any dentist, hospital, clinic, rehabilitation facility, or other medical practitioner or provider who has or is or will be furnishing services to me to provide my medical and dental information, including history, treatment, diagnosis and prognosis; and

2. Any firm or employer to furnish information about my earnings, loss of earnings, work history, and medical information in their possession to:

INDIANA FARMERS MUTUAL INSURANCE COMPANY and its claim or legal representatives.

This information is authorized to permit the evaluation and resolution of a claim I have made against **INDIANA FARMERS MUTUAL INSURANCE COMPANY** and/or their insured(s) arising out of an accident or loss that occurred on or about the _____ day of _____, _____.

This authorization can be revoked, at any time, by notifying **INDIANA FARMERS MUTUAL INSURANCE COMPANY** in writing. I agree a photocopy of this authorization is as valid as the original. I can receive a copy of this authorization upon request.

NOTICE: "A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony."

_____
Signature of patient/employee, personal representative or next of kin

_____
Patient's social security number

_____
Patient's date of birth

_____
Date

92-202 (1-01)