

Authorization for Insurer to Investigate

I, , hereby authorize (Insurance Company), its representatives and agents, to investigate all facts, records, and information related to my claim or application, including but not limited to medical records, employment records, and any other relevant documents or testimony.

This authorization is given pursuant to my claim/application for insurance benefits under policy number .

I understand that this investigation may include contacting healthcare providers, employers, government agencies, and other persons or entities as necessary to verify the information provided.

This authorization is valid for a period of months from the date signed below, unless revoked by me in writing prior to that date.

Signed:

Date: