Authorization to Release Information

AccordiaLife
www.accordia.com

Accordia Life and Annuity Company
P.O. Box 305027, Nashville, TN 37230-5027
Customer Contact Center – Tel: 877 462 8992 Fax: 800 351 0603

Accordia Life and Annuity Company
215 10th Street, Suite 1100, Des Moines, IA 50309

First Allmerica Financial Life Insurance Company
132 Turnpike Road, Suite 210, Southborough, MA 01772

INSTRUCTIONS

- Use this form to designate 1 or 2 authorized individuals to obtain information about your policy/contract(s).
- This authorization allows for the release of information ONLY. It does NOT allow the authorized person to make changes to the policy/contract(s) listed on this release form.
- You can also call one of our Customer Contact Centers listed above to make this request.
- Attached documentation must be signed and dated by the owner.
- This authorization is valid until revoked by the owner. The owner reserves the right to revoke this authorization at any time for any reason by calling us at the number listed above or by submitting a written request.
- When contacting our offices the authorized party will need to verify the last four digits of the OWNER'S Social Security Number, the OWNER'S date of birth and the OWNER'S password (if applicable) when requesting information.

1. INFORMATION ABOUT THE OWNER

Individual, Trustee or Company Name		Contract/Policy Number(s)		
If Trust, list Trust Name and Trust Date				
Mailing Address		City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number (last four digits) X X X - X X -	Date of Birth (mm/dd/yy) / /	Email Address		
Personal Phone ( ) -	Business Phone ( ) -	☐ Address Change Requested (Confirmation of this change will be sent to you prior to processing this request.)		

2. AUTHORIZED PARTY #1

Full Name*				
Mailing Address*		City*	State*	Zip*	Country
Street Address (**REQUIRED** if mailing address is a PO Box)		City	State	Zip	Country
Personal Phone ( ) -	Business Phone ( ) -	Email Address		

* Required Information

☐ Check if have attached additional sheets for more than two authorized parties.

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3. AUTHORIZED PARTY #2

Full Name*				
Mailing Address*	City*	State*	Zip*	Country
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country
Personal Phone ( ) -	Business Phone ( ) -	Email Address		

* Required Information

4. LIMITATIONS

Please list below any information you would **not** like to be released to the listed authorized party(ies):

5. YOUR CONFIRMATION

I authorize the named person/people to receive information on the referenced policy/contract(s):

Owner Signature X	Owner's Title (if corporation or trust)	Date (mm/dd/yy) / /
Joint Owner Signature X	Print Name	Date (mm/dd/yy) / /

If you are signing on behalf of the owner, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature X	Print Name	Date (mm/dd/yy) / /

We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, contact your Insurance Professional or our Contact Center.