

CONSENT / RELEASE OF INSURANCE INFORMATION

Insurance Company Name & Address

Galen Insurance Company in Liquidation
c/o DIFP Receivership Section
P.O. Box 690
Jefferson City, MO 65102

I authorize the insurance carrier listed above to release a copy of the following insurance documents to the recipient listed below.

1. Claim History / Run Loss Report

Please send the documents to:

Name: _____

Address: _____

City/State/Zip: _____

Attn: _____

Additional Recipients: (Name / E-mail / Address)

Policy Holder Name: _____

Insured Name: _____

Policy Number (s): _____

Insured Signature: _____

Date: _____