This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of Birth	Last Four of SSN
Name of Secondary Proposed Insured/Patient	Date of Birth	Last Four of SSN

I hereby authorize the use or disclosure of health information, as described below, about me or my above-namedunemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician,health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy,pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurancesupport organization such as MIB Group, Inc., or other medical practitioner or health care provider that has providedpayment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** TheCompanies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorizethe Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates aninformation exchange on behalf of life and health insurance companie
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the releaseof all information related to my health or that of my unemancipated minor children and my or my unemancipatedminor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses,treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mentalillness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **ThisAuthorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting myinsurance application with the Companies, to support the operations of our business, and, if a policy is issued, forevaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatementof the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacyregulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information aspermitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protectedby federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipatedminor children, the Companies may not be able to process my application, or if coverage is issued may not be able tomake any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already beentaken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under thepolicy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the topof this form. I also

understand that the revocation of this authorization will not affect uses and disclosures of my healthinformation for purposes of treatment, payment and business operations, including agent commission statements.

- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of mycondition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.