

# Application for Life Insurance

Fidelity Life Association, A Legal Reserve Life Insurance Company



Established 1896

PROPOSED INSURED	Full Legal Name of the Proposed Insured: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of Birth: _____ Age: _____ Place of Birth: _____ Social Security Number: _____
	Legal Residence Address: _____ Years _____
	Best Time to Call (if needed): _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Preferred #: (____) _____ Alternate #: (____) _____
	Are you a United States citizen or do you have Permanent Resident Status (a Green Card)? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Driver's License Number: _____ State of Issue: _____
	Occupation: _____ Years in this occupation: _____
Employer or Business Name: _____ Annual Income: \$ _____	

COVERAGE	Product: _____ Face Amount: \$ _____
	Level premium period: _____ years (if applicable).
	<input type="checkbox"/> Dependent Child Rider: \$ _____ <input type="checkbox"/> Waiver of Premium on Total Disability
	<input type="checkbox"/> Accidental Death Benefit: \$ _____ <input type="checkbox"/> Return of Premium/Cash Value (where applicable) Rider
	<input type="checkbox"/> Other Rider or Option: _____ <input type="checkbox"/> Other Rider or Option: _____
	<input type="checkbox"/> Other Rider or Option: _____ <input type="checkbox"/> Other Rider or Option: _____
Mode of Payment: _____ Billing Method: _____ Amount Paid With Application: \$ _____	
<b>Not all Products or Riders are available in all States. Refer to Product Guide for details.</b>	

OTHER COVERAGE	Do you have any existing life insurance in force or is any application for life insurance, or reinstatement, now pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Name of Company: _____ Face Amount: \$ _____ Year Issued: _____ To Be Replaced? <input type="checkbox"/> Yes <input type="checkbox"/> No
If this policy is issued, will any other existing life insurance or annuity be cancelled, terminated, lapsed or not renewed? <input type="checkbox"/> Yes <input type="checkbox"/> No	

OWNER AND BENEFICIARY	Policyowner <i>(The Policyowner will be the Proposed Insured unless otherwise indicated)</i>			
	Name of Policyowner: _____	Relationship to Insured: _____	SSN/Tax ID: _____	
	Billing Address: _____			
	Secondary Addressee <i>(Optional. This person will receive copies of your overdue premium and lapse notices)</i>			
	Name: _____	Mailing Address: _____		
	Beneficiary <i>(Complex beneficiary designations should be dealt with within the context of a Will)</i>			
	Primary: _____	Percent of Proceeds _____	Relationship to Insured: _____	SSN/Tax ID: _____
Contingent: _____	Percent of Proceeds _____	Relationship to Insured: _____	SSN/Tax ID: _____	
If more space is needed attached a separate, signed and dated sheet of paper.				

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Name of Proposed Insured:

1. Do you have a regular physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give information below. If No, show the last physician seen.	
Name of physician: _____	Date last seen: _____
Address: _____	Telephone: _____
2a. Your Height: _____ ft/in Your Weight: _____ lbs. 2b. Have you lost weight in the past year? <input type="checkbox"/> Yes _____ lbs. <input type="checkbox"/> No	
3. Have you, within the past 10 years, been treated by a licensed member of the medical profession for or been diagnosed as having:	
a. a heart disorder, including a heart attack (myocardial infarction), angina, irregular heart beat or abnormal heart rhythm (arrhythmia), heart murmur, any blockage or narrowing of the arteries, any aneurysm, stroke, or transient ischemic attack (TIA or mini-stroke)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. diabetes, high blood sugar, sugar in the urine, anemia, blood or platelet disorders, liver disease, kidney disease (other than kidney stones), Crohn's disease, ulcerative colitis, other intestinal disease or pancreatitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. internal cancer or tumor, melanoma, lymphoma, leukemia,?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Alzheimer's disease (dementia), memory loss, seizures, mental retardation (including Down's syndrome), Multiple Sclerosis (MS), Muscular Dystrophy, Parkinson's disease, Amyotrophic Lateral Sclerosis (ALS), cerebral palsy or any form of muscular atrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. sleep apnea, cystic fibrosis, emphysema or chronic obstructive lung disease (COLD), rheumatoid arthritis, paralysis, connective tissue disorder (lupus or scleroderma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. enlarged prostate or elevated prostate specific antigen (PSA) or any disorder of the breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. hypertension (high blood pressure), elevated cholesterol, asthma or other respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. anxiety, depression, eating disorders or any other psychological or emotional disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you, within the past 12 months, received disability benefits of any kind or been disabled for more than 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Other than as already disclosed above, are you currently taking any medication (by prescription or over the counter), or receiving medical or mental health treatment of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Was the reason you last consulted your physician for any reason other than as already disclosed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Have you, within the past 5 years:	
a. been a patient in any hospital, clinic, dependency program, halfway house or other medical facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. used controlled substances such as cocaine, heroin, amphetamines, barbiturates or hallucinogens?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. been treated by or been advised by a physician to seek treatment for drug or alcohol use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. been advised to have any test (except HIV tests), treatment, surgery, hospitalization or consultation with a medical professional which has yet to be completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. had an application for life or health insurance rated up, postponed, declined or denied reinstatement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. To the best of your knowledge or belief has more than one natural parent or sibling died of cancer or heart disease prior to age 60? <input type="checkbox"/> Yes <input type="checkbox"/> No	
9. Have you, within the past 24 months, used any form of tobacco or nicotine product, including cigarettes, cigars, pipes, chewing tobacco, snuff, nicotine patches or nicotine gum? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, have you, within the past 12 months, used any form of tobacco or nicotine product? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Have you, within the past 2 years, engaged in or, in the next 2 years do you plan to engage in:	
a. any aviation activity other than as a fare-paying passenger on commercial airlines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. any form of scuba diving, hang-gliding, cave exploration, parachuting, mountain, rock or ice climbing, bungee jumping or organized motor racing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you, within the past 2 years, had a driver's license suspended, revoked or been convicted of more than three moving violations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Have you, within the past 5 years, been convicted of driving while under the influence of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Are you currently on probation or have you, within the past 5 years, been convicted of a felony? <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Do you intend to travel, live, or work outside the United States or Canada? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PROVIDE DETAILS OF ANY YES ANSWERS ON THE PAGE 3.

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Name of Proposed Insured:

### LIST ALL DEPENDENT CHILDREN TO BE INSURED

If more space is needed, list full information on all additional dependent children on a separate, signed sheet.

B - DEPENDENT CHILD RIDER

- B1. Full Legal Name of Dependent Child: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Relationship to the Proposed Insured: \_\_\_\_\_
- B2. Full Legal Name of Dependent Child: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Relationship to the Proposed Insured: \_\_\_\_\_
- B3. Full Legal Name of Dependent Child: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Relationship to the Proposed Insured: \_\_\_\_\_
- B4. Full Legal Name of Dependent Child: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Place of Birth: \_\_\_\_\_ Relationship to the Proposed Insured: \_\_\_\_\_
- B5. Does any Child to be insured have any existing life insurance in force or is there an application for life insurance now pending on any Child to be insured? *(If yes, please provide name of company and policy number.)*.....  Yes  No  
 Name of Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_
- B6. If this coverage is issued, will any existing life insurance or annuity on any Child to be insured be cancelled, terminated, lapsed or not renewed? *If Yes, give full details below.* .....  Yes  No
- B7. Does any Child to be insured been diagnosed with or treated by a licensed member of the medical profession for any physical disability, mental retardation or special need? .....  Yes  No
- B8. Has any Child to be insured been diagnosed with or treated by a physician for any disorder of the heart or has any surgery or hospitalization been suggested which has not yet been completed? .....  Yes  No

**PROVIDE DETAILS OF ANY YES ANSWERS BELOW.**

DETAILS OF YES ANSWERS (IF ANY)

*Show question being answered, the condition(s), the name, address and phone number(s) of the physician(s) and the prescribed medication(s).*

Question      Answer

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Name of Proposed Insured:

<b>PRE-AUTHORIZED PAYMENT AUTHORIZATION</b>	<p>As a convenience to me, I authorize Fidelity Life Association, A Legal Reserve Life Insurance Company ("Fidelity Life") to make electronic debits or other forms of preauthorized withdrawals from my financial institution as indicated below. I understand that if a debit or withdrawal is not honored by the financial institution, Fidelity Life will consider the premium unpaid. Any debit or withdrawal returned due to insufficient funds may be redeposited by Fidelity Life. This authorization will remain in effect until written notice by the depositor/card holder is received by Fidelity Life. I further agree that if any such debit or withdrawal is not honored, whether with or without cause, Fidelity Life shall be under no liability whatsoever even though such dishonor results in the lapse of insurance, in accordance with the grace period.</p>
	<p><b>PRE-AUTHORIZED CHECK</b></p> <p><input type="checkbox"/> I request that my premium payments be debited from my bank account as shown. Name of Bank: _____ Transit Number: _____ Account Number: _____</p>
	<p><b>PRE-AUTHORIZED CREDIT CARD</b></p> <p><input type="checkbox"/> I request that my premium payments be debited from the credit card shown below. <input type="checkbox"/> Visa <input type="checkbox"/> Amex <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover Card Number: _____ Expiration Date: _____</p> <p>_____ Printed Name (As it appears on file with the financial institution) AUTHORIZED SIGNATURE</p>

<b>DECLARATION, AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION</b>	<p>I declare that each answer and statements given to the questions contained in this application is complete and true to the best of my knowledge and belief. I understand and agree that Fidelity Life will rely on these answers, and the answers and statements I may give in any other form taken as a part of this application as representations and not warranties and that no such statement shall void the policy unless it is contained in a written application and a copy of such application shall be endorsed upon or attached to the policy when issued. I also understand that Fidelity Life reserves the right to accept or deny this application after taking into account whatever information may be available to it, including availability as to coverage by its reinsurers.</p>
	<p>The coverage will be effective on its date of issue if the: (a) health; (b) avocations; (c) occupation; and (d) any other condition relating to the Proposed Insured are as described in the application. The effective date is the Policy Date shown on page 3.</p> <p>I, the Proposed Insured, authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau (MIB), consumer reporting agency or employer to give to Fidelity Life any information they might have regarding the diagnosis, treatment, prescription and prognosis of any physical or mental condition, my driving record, avocations, credit history, insurance history, occupation, character and hobbies, as applicable. To facilitate the rapid transmission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by Fidelity Life to collect and transmit such information.</p> <p>I agree that this authorization shall remain in effect for two years (24 months) from the date that it is signed and that a copy of it shall be as valid as the original. I understand that the information obtained with this authorization shall be used to evaluate my application for insurance. I understand that I, or someone I authorize to act on my behalf, may obtain a copy of this authorization. I also understand that I have the right to revoke this authorization at any time.</p> <p>All or part of such information may be disclosed to a physician of my choosing, my insurance agent, the Medical Information Bureau (MIB), to other persons or organizations performing business or legal services in connection with this application, including reinsuring companies and as may be required by law.</p> <p>Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>Signed at: (City and State) _____ Date: _____</p> <p>_____ Signature of Policyowner, if other than the Insured Signature of Proposed Insured</p>

<b>AGENT</b>	<p>To the best of your knowledge, will the coverage applied for replace any existing life or annuity coverage now in force on the life of the Proposed Insured?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does any Proposed Insured have existing life insurance policies or annuity contracts in force? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If any Proposed Insured has existing life or annuity coverage complete the notice regarding replacements.</b></p>
	<p>Printed Name of Agent: _____ Agent ID: _____ General Agent ID: _____</p>
	<p>Email Address of Agent: _____ Telephone Number of Agent: _____</p> <p>State License Number: _____ (if required by law) Signature of Licensed Agent _____</p>

# NOTICE OF INSURANCE INFORMATION PRACTICES

Fidelity Life Association, A Legal Reserve Life Insurance Company



We appreciate your application and thank you for choosing **Fidelity Life Association** for your life insurance needs. In order for us to continue to provide cost effective coverage to our clients, we need to evaluate each application fully. To complete our underwriting evaluation, we may need to obtain medical and other personal information about you. When you sign the Declaration, Agreement and Authorization to Release Information section of the application, you give us permission to obtain that information and give permission to others who have that information to send it to us.

We recognize our obligation to protect your privacy and the confidentiality of underwriting information we obtain about you. For that reason, we have procedures for obtaining information and controlling access to our files that we want you to know about it. In addition, Federal and State regulators require that certain information about the underwriting process be given to you. This information is included in the following paragraphs.

**Insurance Information Practices.** To evaluate your application, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

**Fair Credit Reporting.** As part of our evaluation of your application, an investigative consumer report may be prepared, whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health and mode of living. Upon your written request and within a reasonable period of time, you have the right to receive additional information about the nature and the scope of the investigation and to receive a copy of the report at your expense.

**Medical Information Bureau.** Information regarding your insurability will be treated as confidential. Fidelity Life Association, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member for Life or Health insurance, or a claim for benefits is submitted to such a company MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of any information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

Fidelity Life Association, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**THIS NOTICE IS TO BE LEFT WITH THE APPLICANT**

## Important Notice

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To obtain information or make a complaint:

You may call Fidelity Life Association's toll-free telephone number for information or to make a complaint at:

800- 369-3990

You may also write to Fidelity at:

1211 West 22<sup>nd</sup> Street, Suite 209  
Oak Brook, IL 60523

You may write the Texas Department of Insurance at:

P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

800-252-3439

### **Premium or Claim Disputes**

Should you have a dispute concerning your premium or about a claim, you should contact the agent or the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

### **Attach This Notice to Your Policy/Certificate**

This notice is for information only and does not become a part or condition of the attached document.

## Aviso Importante

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Para obtener information o para someter una queja:

Usted puede llamar al numero de telefono gratis de LSW's para informacion o para someter una queja al

800- 369-3990

Usted tambien puede escribir a IAP:

1211 West 22<sup>nd</sup> Street, Suite 209  
Oak Brook, IL 60523

Puede escribir a! Departamento de Seguros de Texas

PO. Box 149104  
Austin, TX 78714-9104  
PAX # (512) 475-1771

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companies, coberturas, derechos o quejas al

800-252-3439

### **Disputas Satire Primas o Reclamos**

Si llene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el agente o la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

### **Una Este Avlso a Su POlim/Certificado**

Este aviso es solo para proposito de informacion y no se convierte en parte o condici6n del documento adjunto.

## **Important Information About Coverage Under The Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association**

**I**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

### **Eligibility for Protection by the Association**

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of insurance, the Association provides coverage to policyholders who are:

- **residents of Texas** at the time that their insurance company is impaired.
- **residents of other states**, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company based in Texas;
  2. The company has never held a license in the policyholder's state of residence;
  3. The policyholder's state of residence has a similar guaranty association; and
  4. The policyholder is not eligible for coverage by the guaranty association of the policy-holder's state of residence.

### **Limits of Protection by the Association**

#### **Accident, Accident and Health, or Health Insurance:**

- up to a total of \$200,000 for one or more policies for each individual covered.

#### **Life Insurance:**

- net cash surrender value up to a total of \$100,000 under one or more policies on any one life, or
- death benefits up to a total of \$300,000 under one or more policies on any one life.

#### **Individual Annuities:**

- net cash surrender amount up to a total of \$100,000 under one or more policies owned by one contractholder.

#### **Group Annuities:**

- net cash surrender amount up to \$100,000 in allocated benefits under one or more policies owned by one contractholder; or
- net cash surrender amount up to \$5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on *coverage* by the Association.

Texas Life, Accident, Health & Hospital  
Service Insurance Guaranty Association  
301 Congress, Suite 500  
Austin, Texas 78701

Texas Department of insurance  
P.O Box 149104  
Austin, Texas 78714-9104  
800-252-3439 800-982-6362

# HIPAA AUTHORIZATION

Fidelity Life Association, A Legal Reserve Life Insurance Company



Established 1896

## Authorization for the Release of personal Health Information

This authorization complies with the **HIPAA** Privacy Rules

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any entity subject to the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Fidelity Life Association, its agents, employees, representatives, insurance support organizations, and reinsurers (collectively, "the Company"). This includes all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including but not limited to, hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer and/or any entity subject to HIPAA to release and disclose such information without restriction.

I understand that unless prohibited by state and/or Federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by Federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This authorization shall remain in force for 26 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company at the address listed above. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application for insurance. I understand that I am entitled to receive a copy of this authorization.

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PRINTED NAME OF THE PROPOSED INSURED

DATE OF BIRTH

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SIGNATURE OF THE PROPOSED INSURED

DATED

Or, if applicable, signature of the Personal Representative of the Proposed Insured

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If applicable, description of Personal Representative's authority or relationship to Proposed Insured.

**THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY**