



Authorization for Release of Health Information to:

Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
877-777-8808

I/you authorize any: health care provider; hospital; clinic; laboratory; pharmacy; or any similar organization, institution, or person that has knowledge or records of me and my health to disclose any and all health information concerning me, up to and including my entire medical record (except HIV). This includes information about my mental health; any STDs; substance and or alcohol use, or any other non-health history to be released. I/you authorize the release of such records to Senior Life Insurance Company and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.

I/you authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to Senior Life Insurance Company or its reinsurer . I/you also authorize Senior Life Insurance Company or its reinsurer, to make a brief report of my personal health information to MIB, Inc.

The records being released will be used to determine eligibility for insurance. There is a possibility that the records provided will be re-disclosed. If the records are disclosed, they may no longer be protected by California privacy laws. This authorization will be valid for twenty-four (24) months from the date the authorization is signed. You may revoke this authorization at any time by sending a written request to us at the address shown above. If I revoke this authorization, the rights of any individual who used my records based on my authorization, prior to receiving notice of my revocation, will not be affected. I can refuse to sign this authorization. If I do not sign, my application may not be accepted, or my claim may be denied.

Policy Number

Proposed Insured's Printed Name

Date of Birth

Social Security Number

Proposed Insured's Signature

Date

Authorized Representative's Signature

Relation to Insured

Date



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CALIFORNIA FRAUD ENDORSEMENT

For your protection California law requires the following statement to appear on this form.

“Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.”

The coverage under the Policy to which this Endorsement is attached remains the same.