Authorization for Release of Health Information to:
Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447

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

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as Medical Information Bureau, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Senior Life Insurance Company (and referred to in this Authorization as the "Company") and its Policy Services and Claims Department. This includes information on the diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), sexually transmitted diseases, information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical records without restrictions.

This 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 or have applied for with the Company.

I understand that this Authorization shall remain in force for thirty (30) months or the duration of the claim, whichever is longer, 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 in writing, at any time, by sending a written request for revocation to the Company, Attention: HIPAA Privacy Official to the address listed above. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information. However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I am entitled to receive a copy of this Authorization Form. My Authorized Representative is also entitled to receive a copy of this Authorization Form.

Proposed Insured's Printed Name	Date of Birth	Social Security Number

Proposed Insured's or Authorized Representative's Signature	Date

Description of Authorized Representative's Authority with appropriate documents attached (if applicable)