Life Investors Insurance Company of America Monumental Life Insurance Company Stonebridge Life Insurance Company Transamerica Life Insurance Company Western Reserve Life Assurance Co. of Ohio 4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)
hereby authorize the use or disclosure of health information, as described evoke any previous restrictions concerning access to such information:	below, about me or my above-n	amed unemancipated minor children and
Person(s) or group(s) of persons authorized to use and/or disclose hospital, clinic, long-term care facility, medical or medically-related facil [including the Companies noted above (the "Companies")], insurance suphealth care provider that has provided payment, treatment or services to person(s) or group(s) of persons authorized to collect or otherwise reinsurers, and their agents, employees, or other representatives. I furth the information to MIB Group, Inc., which operates an information exchant Description of the information that may be used or disclosed: This authority that of my unemancipated minor children and my or my unemancipated information on the diagnoses, prognoses, treatments, prescription drug inform illness, communicable or infectious conditions, such as AIDS (except HIV exabuse treatment. This Authorization excludes psychotherapy notes that a The information will be used or disclosed only for the following pur Companies and, if a policy is issued, for evaluating contestability and reinstatement of the policy or to contest a claim under the policy.	lity, laboratory, pharmacy, pharmacy pport organization such as MIB G me or on my behalf or to or on below the information are authorize the Companies and inge on behalf of life and health instriction specifically includes the releminor children's insurance policie mation, and information regarding deposure/testing), and use of alcohol, are separated from the rest of my rpose(s): For the purpose of under the rest of my rpose(s):	acy benefit manager, insurance company roup, Inc., or other medical practitioner of half of my unemancipated minor children. Ition: The Companies, their affiliates and their affiliates and reinsurers to redisclose urance companies. Pease of all information related to my health of and claims, including, but not limited to diagnosis, prognosis and treatment of mental drugs and tobacco including alcohol or drug medical records.
TATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:  I understand that health information about me provided to the Companies reprivacy Rule and that the Companies will only use and disclose such informations. However, I also understand that any information disclosed under a longer be protected by federal regulations such as the HIPAA Privacy Rule I understand that if I refuse to sign this authorization to release my heal may not be able to process my application, or if coverage is issued may reprive I understand that I may revoke this authorization in writing at any time, extend that other law provides the Companies with the right to contest to the Companies' Privacy Official at the address at the top of this form. I and disclosures of my health information for purposes of treatment, paymed This authorization shall remain in force for 24 months from the date signed acknowledge I have received a copy of this authorization.	mation as permitted by applicable rethis authorization may be subject to governing privacy and confidential the information or that of my unermoted be able to make any benefit packet to the extent that action has to a claim under the policy or the policy or the policy understand that the revocationent and business operations, included.	egulations and as described in their privacy or edisclosure by the recipient and may not ity of health information.  nancipated minor children, the Companies syments.  already been taken in reliance on it, or to olicy itself, by sending a written revocation on of this authorization will not affect uses uding agent commission statements.
ignature of Primary Proposed Insured/Patient or Personal Representative		Date
ignature of Secondary Proposed Insured/Patient or Personal Representative	<u> </u>	Date
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signed by an individual's personal representative or the parent or guar f the individual:	dian of an unemancipated mino	r, describe authority to sign on behalf

A copy of this authorization will be considered as valid as the original.

Life Investors Insurance Company of America Monumental Life Insurance Company Stonebridge Life Insurance Company Transamerica Life Insurance Company Western Reserve Life Assurance Co. of Ohio 4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

Name of Secondary Proposed InsurediPatient  Date of birth  Last four digits of SSN  Name(s) of Unemancipated Minors  Date(s) of birth  Last four digits of SSN(s)  I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor childrer revoke any previous restrictions concerning access to such information:  Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care profess hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance cor [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practition health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor childrer reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redit the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.  Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my the that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limi information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of illness, communicable or infectious conditions, such as AIDS (except HIV exposuretesting), and use of alcohol, drugs and blosacco including alcohol cabuse treatment. This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.  The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance app	This authorization complies with the Health Insurance Portability a Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors  Date(s) of birth  Last four digits of SSN(s)  I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor childre revoke any previous restrictions concerning access to such information:  Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care profess hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance con [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practition health care provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children representatives. I further authorize the Companies and their affiliates and reinsurers to redit the information to MIB Group, Inc., which operates an information exchange on behalf of life and health incomance companies.  Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my he that of my unemancipated minor children and my or my unemancipated minor children and my or my unemancipated minor children information on the diagnoses, prognoses, treatments, prescription drug information, and information reparking gionsis, prognosis and retament of illness, communicable or infectious conditions, such as AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or abuse treatment. This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.  The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance application we Companies and, if a policy is issued, for	Name of Finnary Proposed Insured/Fallon	Date of Sitti	Last lour digits of Solv
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<ul> <li>I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their protects. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and monger be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.</li> <li>I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Company not be able to process my application, or if coverage is issued may not be able to make any benefit payments.</li> <li>I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revote to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.</li> <li>This authorization shall remain in force for 24 months from the date signed, regardless of my condition and whether living or deceased.</li> <li>I acknowledge I have received a copy of this authorization.</li> </ul>	<ul> <li>hospital, clinic, long-term care facility, medical or medically-related facili [including the Companies noted above (the "Companies")], insurance suphealth care provider that has provided payment, treatment or services to rate of the person of the person of persons authorized to collect or otherwise reinsurers, and their agents, employees, or other representatives. I further the information to MIB Group, Inc., which operates an information exchan</li> <li>Description of the information that may be used or disclosed: This author that of my unemancipated minor children and my or my unemancipated information on the diagnoses, prognoses, treatments, prescription drug inform illness, communicable or infectious conditions, such as AIDS (except HIV expanduse treatment. This Authorization excludes psychotherapy notes that at the information will be used or disclosed only for the following pur Companies and, if a policy is issued, for evaluating contestability and expanding the provided in the companies and in a policy is issued, for evaluating contestability and expanding the companies and in a policy is issued, for evaluating contestability and expanding the companies and in a policy is issued, for evaluating contestability and expanding the companies and in t</li></ul>	ity, laboratory, pharmacy, pharm opport organization such as MIB (me or on my behalf or to or on be the receive and use the information are authorize the Companies and ge on behalf of life and health instriction specifically includes the reliminar children's insurance policie mation, and information regarding to cosure/testing), and use of alcoholate separated from the rest of my pose(s): For the purpose of und	nacy benefit manager, insurance company Group, Inc., or other medical practitioner or chalf of my unemancipated minor children. ation: The Companies, their affiliates and their affiliates and reinsurers to redisclose surance companies. lease of all information related to my health or es and claims, including, but not limited to diagnosis, prognosis and treatment of mental, drugs and tobacco including alcohol or drug y medical records. lerwriting my insurance application with the
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Signature of Secondary Proposed Insured/Patient or Personal Representative	Signature of Primary Proposed Insured/Patient or Personal Representative		Date
orginations of secondary interpresent affects of increasing the representative	Signature of Secondary Proposed Insured/Patient or Personal Representative		Date
If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on be		dian of an unemancipated mine	or, describe authority to sign on behalf
of the individual:  Parent Legal guardian Power of Attorney Doubler (please describe):		Other (please describe):	
(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)		.,	tive applies.)

A copy of this authorization will be considered as valid as the original.