



Authorization for Release of Health-Related Information

Send Information to: New Business & Administrative Office
One Sammons Plaza, Sioux Falls, SD 57193

This Authorization complies with the HIPAA Privacy Rules

Name of Proposed Insured _____
(Please print)

Birth Date _____ / _____ / _____
Month Day Year

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The North American Company for Life and Health Insurance and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, 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 my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that North American Company for Life and Health Insurance may: 1) underwrite my application for coverage, determine 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 North American Company for Life and Health Insurance .

This Authorization shall remain in force for 30 months following the date of my signature below. If this authorization is used for claim purposes, it shall remain in force for the duration of the claim. 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 North American Company for Life and Health Insurance at One Sammons Plaza, Sioux Falls, SD 57193 Attention: New Business.



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 North American Company for Life and Health Insurance has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this Authorization to release my complete medical record, North American Company for Life and Health Insurance the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge by my signature below, that I or my Personal Representative have a right to receive, and have in fact received, a copy of this authorization.

Signature of Proposed Insured or Personal Representative

Date

(MM/DD/YYYY)

If you are the Personal Representative of the Proposed Insured, describe the scope and/or basis of your authority to act on the Insured's behalf:
