Banner Life Insurance Company
[3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428]

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

Print Name of Proposed Insured/Patient

Date of Birth

Print Name of Person or Organization Providing Information

AUTHORIZATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to **Banner Life Insurance Company**, its agents, employees, vendors or representatives. Any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released. This includes information on sexually transmitted diseases other than HIV. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; and any genetic information or genetic testing results. **This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such tests results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.**

I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to Banner Life Insurance Company, its reinsurer(s), or any MIB-authorized third-party administrator performing underwriting services on Banner Life Insurance Company's behalf. I also authorize Banner Life Insurance Company, its reinsurer(s) or authorized third-party administrator, to make a brief report of My Information to MIB, Inc.

My Information is to be disclosed under this authorization so that **Banner Life Insurance Company** may: 1) underwrite my application for coverage, make eligibility, risk rating, and policy issuance 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 **Banner Life Insurance Company.**

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider, or other entity to release and disclose My Information, including my entire medical record without restriction. **This is not to include HIV or the HIV virus.**

This authorization will be valid for two (2) years or a lesser time limit as required by applicable law in the jurisdiction in which any policy is issued.

I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at [3275 Bennett Creek Avenue, Frederick, Maryland 21704, Attention: Privacy Official]. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that the Company has taken action in reliance on this Authorization or 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 certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign, alter, or revoke this Authorization the Company may not be able to process my application and it may be a basis for denying my request for coverage, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Signature of Proposed Insured/Patient

Date (required)

Social Security Number of Proposed Insured

Agent or Witness Signature