**Banner Life Insurance Company**
[3275 Bennett Creek Avenue
Frederick, Maryland 21704
800-638-8428
www.LGAmerica.com]

# HIPAA Release Transfer Authorization

**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 agree that as part of my application for life insurance with Banner Life Insurance Company (the "Company") I completed a HIPAA compliant Authorization to Obtain and Disclose Information allowing the Company and its agents, employees, vendors, or representatives (collectively referred to as "Recipients") to access my medical, personal health information, and other personal or private information from, among others, 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, Kaiser Permanente, Veterans Administration facility, or other medical or medically related facility (collectively referred to as "Providers"). I further agree and authorize the Recipients, via my signature below, to electronically apply my signature, concurrent with the date of this HIPAA Release Transfer Authorization, to any other HIPAA compliant medical release and/or health authorization requested or required by any of my Providers, including, but not limited to: medical practitioners, pharmacists, Pharmacy Benefit Managers, medical facilities (including hospitals and facilities run by Kaiser Permanente, the Veterans Administration, the Mayo Clinic, the Cleveland Clinic). This HIPAA Release Transfer Authorization shall be valid for twenty-four (24) months from the date of my signature and shall survive my death or disability, subject to any right I may have to revoke this authorization.

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 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.

Signature of Proposed Insured/Patient

Date

Social Security Number of Proposed Insured

Agent or Witness Signature