HIPAA AUTHORIZATION

Fidelity Life Association, A Legal Reserve Life Insurance Company

FIDELITYLIFE
Established 1896

Authorization for the Release of personal Health Information

This Authorization complies with the **HIPAA** Privacy Rules

I authorize any: 1) physician; 2) health care professional; 3) hospital; 4) clinic; 5) laboratory; 6) pharmacy; 7) pharmacy benefit manager; 8) medical facility; 9) health care provider; 10) health plan; 11) insurer; 12) and/or any entity subject to the **Health Insurance Portability and Accountability Act** of 1996 (HIPAA) that has provided: 1) treatment; 2) service; 3) payment; or 4) coverage to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to: 1) Fidelity Life Association; 2) its agents; 3) employees; 4) representatives; 5) insurance support organizations; and 6) reinsurers (collectively, "the Company"). This includes all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including but not limited to: 1) hospital records; 2) treatment records/office notes; 3) consultation reports; 4) workers' compensation information; 5) diagnosis; 6) prescriptions; and 7) test results. It also includes information concerning: 1) the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases; 2) the diagnosis and treatment of mental illness; 3) and the use of alcohol, drugs, and tobacco.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any: 1) physician; 2) health care professional; 3) hospital; 4) clinic; 5) laboratory; 6) pharmacy; 7) pharmacy benefit manager; 8) medical facility; 9) health care provider; 10) health plan; 11) insurer; 12) and/or any entity subject to HIPAA to release and disclose such information without restriction.

I understand that unless prohibited by state and/or Federal law, the 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, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this Authorization may no longer be covered by Federal rules governing privacy and confidentiality of health information and may be subject to redisclosure.

This Authorization shall remain in force for 26 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective: 1) to the extent that the Company has already relied on this Authorization; 2) to the extent that the Company has a legal right to contest a claim under an insurance policy or; 3) to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA. No action relating to this Authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this Authorization, the Company may not be able to process my application for insurance. I understand that I am entitled to receive a copy of this Authorization.

PRINTED NAME OF THE PROPOSED INSURED. DATE OF BIRTH.

SIGNATURE OF THE PROPOSED INSURED. DATED.
Or, if applicable, signature of the Personal Representative of the Proposed Insured.

If applicable, description of Personal Representative's authority or relationship to Proposed Insured.

THIS PAGE IS TO BE SIGNED AND SENT TO THE COMPANY.