North American Company for Life and Health Insurance

L3100SM

Authorization for Release of Health-Related Information

Name of Proposed Insured (Please Print)	Birth Date (Month/Day/Year)	Last 4 digits of Social Security #

I HEREBY REQUEST AND AUTHORIZE: Any licensed physician, medical practitioner, health care professional, hospital, clinic, or other medically-related facility, laboratory, pharmacy, pharmacy benefit manager, MIB, Inc., consumer reporting agency, insurance support organization, or independent administrator having information available about me,
(List specific entity below if required)

to release the specified information from my records to North American Company for Life and Health Insurance ("North American") at the address shown bottom of this form, or to any person or entity acting on behalf of North American.

The information is to be disclosed under this authorization so that North American may: 1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with North American.

THIS DISCLOSURE INCLUDES THE FOLLOWING INFORMATION: All records pertaining to my medical treatment, including History and Physical, Operative Report(s), Consultation Report(s), X-Ray Report(s), Discharge Summary, Pathology Report(s), Laboratory Report(s), Doctor/Clinic Notes, Prescription History, and Medications for the period 10 years prior to the date this Authorization is signed.

I understand that the information to be disclosed may include diagnosis, prognosis, and treatment for physical, psychological, psychiatric and emotional illness, treatment of alcohol or drug abuse, communicable or non-communicable diseases, Acquired Immune Deficiency Syndrome, HIV testing, Hepatitis A, B, C, and sickle cell anemia.

A photographic or faxed copy of this authorization shall be valid as the original. I may revoke my consent at any time upon written request directed to the North American Administrative Office, except to the extent that any of my providers has relied on this authorization or to the extent that North

North American Company • Administrative Office New Business Processing Center: P. O. Box 5089, Sioux Falls, SD 57117 • Principal Office: West Des Moines, IA
Phone: (800) 800-3656 Fax: (800) 951-9430 • www.NorthAmericanCompany.com

American has a legal right to contest a claim under an insurance policy or to contest the policy itself. I have a right to inspect and obtain a copy of the records and this authorization. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the HIPAA rule. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining my authorization. I have a right to refuse to sign this authorization.

This consent shall remain in effect for 30 months (24 months in AK, AR, CA, CO, FL, IA, IN, KS, KY, MD, MS, MT, NE, NH, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, WV & WY) from date of signature. This authorization must be signed by me.

Signature Proposed Insured or Personal Representative	Date