Demo Life

HIPAA Authorization for Release of Health-Related Information

DemoLife Life Insurance Company

Home Office: 2700 Commerce Street Suite 1000 Dallas, TX 75226

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Christopher R Smith	10/29/1990	2222
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], insurance support organization such as MIB, LLC, or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: The Company, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Company and their affiliates and reinsurers to redisclose the information to MIB, LLC, which operates an information exchange on behalf of life and health insurance companies.
3. Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. This authorization excludes psychotherapy notes that are separated from the rest of my medical records.
4. The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance application with the Company, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Christopher R Smith — 2025-10-29 06:36

Signature of Primary Proposed Insured/Patient or Personal Representative — Date

Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

☐ Parent ☐ Legal guardian ☐ Power of Attorney ☐ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

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1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], insurance support organization such as MIB, LLC, or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: The Company, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Company and their affiliates and reinsurers to redisclose the information to MIB, LLC, which operates an information exchange on behalf of life and health insurance companies.
3. Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. This authorization excludes psychotherapy notes that are separated from the rest of my medical records.
4. The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance application with the Company, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

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- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
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Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

☐ Parent ☐ Legal guardian ☐ Power of Attorney ☐ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

DemoLife

Withdrawal/Surrender Request

DemoLife Life Insurance Company
Home Office: 2700 Commerce Street Suite 1000 Dallas, TX 75226

SECTION 1. Policy Information (Fill out all information in this section)

☑ Check if Insured and Owner are the same.

A123456	Christopher R Smith
Policy/Certificate #	Policy Owner Name
Christopher R Smith	1618 Texas Ave
Insured Name	Policy Owner Address
1618 Texas Ave	Houston, KY 77003
Insured Street Address	Policy Owner City, State and Zip
Houston, KY 77003	christopher.smith@example.com
Insured City, State and Zip	Policy Owner Email Address

Special Instructions: _____

Is this a new policy owner address? ☐ Yes ☑ No

Please Note: When there's been an address change or change of ownership completed within ten days of a surrender request, the company will delay mailing the payment for ten business days.

SECTION 2. Withdrawal/Surrender (Select only one)

Withdrawal Options:

Distributions May Be Subject To Identity Verification

To help ensure the security of your account and funds, once your distribution request is received, the Company may be obtaining a consumer report from a consumer reporting agency ("CRA") to help verify the validity and accuracy of the account information provided.

I authorize the Company to obtain a consumer report from a CRA as described above, and acknowledge that I: (i) have read the explanation above; (ii) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA in the strictest confidence and as permitted by law and will be retained and used by the CRA only as permitted by law; and (iii) consent to such sharing, retention and use.

☐ Amount of Withdrawal: $_____ ☐ Net Amount or ☐ Gross Amount

☐ Withdrawal from side fund or deposit fund $_____ from _____

☐ Withdrawal/Partial Surrender to pay premiums for policy #_____ due date ____/____/____

Surrender Options:

☑ Request termination of policy/certificate
Once your policy is surrendered, please destroy your policy as it is of no further value. All claims and rights under the contract are forfeited at time of surrender.

☐ Request surrender of a rider only _____

Special Instructions: Surrender old policy once new policy is in force.

Please send disbursement: (Please select only one option)

☑ Regular Mail ☐ Overnight ($20 fee for weekdays, $30 fee for weekends) ☐ Wire ($50 fee, Bank Information is required)

Bank Name | Bank Address

Bank Phone Number | Bank Routing Number | Bank Account Number

Name on Bank Account

SECTION 3. Federal Income Tax Withholding - (Refer to Notice to all Policy Owners)

☐ I elect to have no Federal Income Tax withheld from the taxable portion of the proceeds. (If Federal withholding is elected and your state also requires it, state withholding will be deducted.)

Unless specifically indicated, I have elected to have withholding apply. Any gain included in the distribution if the life insurance policy is considered a MEC may be subject to a 10% federal tax penalty if I am not 59 1/2.

Unless we have been notified of a community or marital property interest in this policy, we will rely on our good faith belief that no such interest exists and will assume no responsibility for inquiry. I further agree to indemnify and protect the existing Insurer from any claim which may be asserted against it under the existing Policy or for any losses, injuries or expenses it may incur as a result of honoring this Agreement. The indemnification shall be binding on my heirs, executors, administrator, successors and assigns.

I certify that I am the Policy Owner and that all information provided by me is correct. I also certify that all decisions regarding this distribution have been made by me, and that no tax advice has been furnished by the Company. I acknowledge that I am personally responsible for any taxes and penalties that may result from this distribution and I release the Company from any responsibility or liability thereof. By signing this form I acknowledge that I have read the information on this form, and that I understand any distributions requested will be subject to applicable policy penalties. I understand that failure to provide the Company with my correct name and Taxpayer Identification Number will result in the Company having to ignore my election out of income tax withholding.

FEDERAL INCOME TAX WITHHOLDING INFORMATION: INTEREST ON DIVIDENDS ON DEPOSIT

Purpose of Statement: A person or payer who is required to file an information return with the IRS must get your correct Taxpayer Identification Number (TIN) to report income paid to you. Giving your correct TIN and making the appropriate certifications will prevent certain payments from being subject to backup withholding. If you do not certify your TIN, the payer may be required to withhold the currently applicable percentage of payments to you.

What is Backup Withholding: Persons or payers making certain payments to you must withhold and pay to the IRS the currently applicable percentage of such payments under certain conditions. This is called "backup withholding." Payments you receive will be subject to backup withholding if:

(1) IRS notifies the payer that you furnished an incorrect TIN, or
(2) You are notified by IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for interest and dividend accounts only,) or
(3) You fail to certify to the payer that you are not subject to backup withholding under (2) above (for interest and dividend accounts opened after 1983 only), or
(4) You fail to certify TIN.

WHEN REQUESTING WITHDRAWAL OR SURRENDER, PLEASE READ THE FOLLOWING:

You have the option to elect to have no Federal Income Tax withheld from the taxable portion of the distribution. However, if you elect not to have withholding apply or if you do not have enough Federal Income Tax withheld, you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

Withholding will apply only to the taxable portion of your distribution. Therefore, tax liability may be calculated on a figure other than the full amount of any distribution. The Company does not provide tax or legal advice. We recommend that you seek advice from a qualified advisor.

If you, the policy owner, are a resident of a state that requires income tax withholding, you are electing not to have amounts withheld for state income taxes when you elect not to have federal income taxes withheld. If state income tax withholding applies, we will withhold the amount required by your state. No election out of withholding may be made for any payment made outside the U.S. unless the payee certifies that he is not a US citizen or US resident alien. 30% must be withheld from the taxable portion of any payment made to non-US citizen or a non-resident alien unless a lower rate is available under a treaty of the United States of America with such person's country. If you qualify for reduced withholding, please file a Form W-8.

WHEN REQUESTING A DISTRIBUTION, PLEASE READ THE FOLLOWING:

A full or partial surrender of a life insurance policy or a loan or other distribution from a life policy that is classified as a Modified Endowment Contract (MEC) for federal income tax purposes is subject to a federal tax penalty under Section 72(v) equal to 10% of any gain in the distribution or loan unless the policy owner is at least 59 1/2 or is disabled. Any distribution or loan from a MEC is considered first to be from gain in the contract and taxable and then a non-taxable recovery of investment or basis in the contract. Please consult with and rely on your tax advisor for any tax advice.

The taxable portion of your distribution is subject to federal (and applicable state) income tax withholding. Alternatively, you may elect to not have federal income tax withheld. If you elect not to withhold taxes from a taxable distribution you may be responsible for payment of estimated tax. You may incur penalties under the estimated tax rules if your withholding and estimated tax payments are not sufficient.

If you, the policy owner, are a resident of a state that requires income tax withholding, you are electing not to have amounts withheld for state income taxes when you elect not to have federal income taxes withheld. If state income tax withholding applies, we will withhold the amount required by your state. The undersigned certifies that; (1) the Policy is not subject to any Lien, assignment, or legal claim by any person or organization who is not a party to this agreement; and (2) that he/she/it is not involved in pending bankruptcy proceedings.

SECTION 4. Signatures

A printed name will not be accepted, please sign with a signature. Please complete all applicable fields — refer to requirements on page 4. Before signing this form please read the Notice to all Policy Owners enclosure that could affect the financial transaction(s).

For residents of **California**: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

Christopher R Smith		10/29/2025
Owner Signature Title (for Trust or Corporation)		Date Signed
2222	10/29/1990	
Social Security Number/Tax ID Number	Date of Birth	
Joint Owner Signature (if applicable)		Date Signed
Joint Owner Social Security Number/Tax ID Number	Date of Birth	
Assignee Signature (if applicable)	Title	Date Signed
Irrevocable Beneficiary Signature (if applicable)		Date Signed

*Under penalties of perjury, I certify:

1) that the number shown on this form is my correct taxpayer identification number, and
2) that I am not subject to backup withholding because
   a. I have not been notified that I am subject to backup withholding as a result of a failure to report all interest or dividends, or
   b. the Internal Revenue Service has notified me that I am no longer subject to backup withholding, and
3) I am a U.S. citizen or U.S. resident for tax purposes

WE WILL NEED: Medallion Signature Guarantee (Variable Life Insurance) or Notary Public Stamp (Fixed Life Insurance) for any withdrawals or surrenders $250,000 or above.

State of _____

County of _____

(Seal)

On this _____ day of _____ (month/year), before me personally

_____
(name of signer)

appeared , and executed the foregoing instrument and acknowledged it to be his/her/its free act and deed.

_____
Notary Public

My Commission Expires _____

If a Medallion Signature Guarantee stamp is required, when faxing please photocopy the Withdrawal/Surrender Form in black and white prior to faxing it since the original green ink may not be visible when faxed.

SIGNATURE REQUIREMENTS

Individual Owners – Must sign this form on the line provided as owner and provide date of birth.

Partnerships – Two authorized partners must sign below the name of the partnership, the title 'partner' must follow each signature.

Corporation is owner – One officer other than the insured or owner must sign below the name of the corporation. The officer's title must follow the signature. A corporate signature is required to support any signature. An entity form or corporate resolution is required.

Trust is the owner – The Trustee must sign using the following layout as an example, "John Doe, trustee under XYZ trust dated June, 1, 1999".

Power of Attorney – The Power of Attorney must sign using the following layout as an example, "John Doe, POA".

Guardian or Conservator or agent acting under power of attorney – The signature of the guardian/conservator or agent acting under a power of attorney must sign on behalf of the owner. Paperwork received from the court should be provided as proof if not already on file with the insurance company.

Beneficiary – Any irrevocable beneficiary must sign this form for a withdrawal request.

Assignee – If the policy has been assigned as collateral security, the assignee must sign this Withdrawal request. If the assignee is a business, an officer of the assignee must sign and include the officer's title (please sign and print).