

**MOUNTAIN LIFE INSURANCE COMPANY**

2416 Sir Barton Way Suite 110  
Lexington, KY 40509  
1-800-888-6542

**HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Name of Proposed Insured (Please print)	Social Security Number	Birth Date
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I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance company, medical facility, the MIB, Inc., the Veterans Administration, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose to Mountain Life Insurance Company, its reinsurer(s), and insurance supporting organizations and their representatives, my entire medical record, prescription history, medications prescribed and any other protected health information concerning me. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize Mountain Life Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB.

By my signature below, I acknowledge that any agreements I have made to restrict my 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 to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Mountain Life Insurance 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 or have applied for with Mountain Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to Mountain Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Mountain Life Insurance Company 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Mountain Life Insurance Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Mountain Life Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

I authorize my employer, any consumer reporting agency, the Department of Motor Vehicles, other organizations, institutions or persons having any records or knowledge of me or my health to release any financial or personal data to Mountain Life Insurance Company or its reinsurers. This information may be used by underwriters, Company Officers, medical and claims personnel in evaluating applications and claims. They may also use it to consider Life and/or Disability insurance and/or benefits applied for by me. I understand this authorization is valid for 24 months from the date it is signed. A copy of it is also valid. I acknowledge having received a copy. I understand that I have the right to revoke this at any time. I also received a copy of **NOTICE OF INSURANCE INFORMATION PRACTICES**. I acknowledge receipt of the Conditional Receipt, if applicable, for Life and/or Disability insurance bearing the same date as this application and certify that I have read it, and its terms, conditions and limitations to which I agree.

Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)
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Signature of Proposed Insured or Personal Representative	Date (MM/DD/YYYY)
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