



Please check the appropriate servicing address of the underwriting company:

- ☐ The Lincoln National Life Insurance Company, Life Service Office: PO Box 21008, Greensboro, NC 27420-1008
☐ The Lincoln National Life Insurance Company, Annuity Service Office: PO Box 2348, Fort Wayne, IN 46801-2348
(hereinafter referred to as "the Company")

Authorization for Release of Information

I (the undersigned) authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of:

Proposed Insured/Patient _____ Date of Birth _____

or the proposed insured's health, including but not limited to complete medical records (including information regarding insurance, referral documents and records from other facilities) or if other, indicate here: _____

to give all such information to The Lincoln National Life Insurance Company (the Company), their licensed representatives and/or their reinsurers, approved vendors, or if other, indicate here: _____

I authorize the Company or its reinsurer to make a brief report of my protected health information to MIB, Inc.

I understand that an authorization for release or disclosure of psychotherapy notes may not be combined with an authorization for release or disclosure of any other information (a separate authorization must be completed for release or disclosure of psychotherapy notes).

I understand that information released may include information regarding testing, diagnosis, and/or treatment of communicable diseases.

I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurers to whom I have applied or may apply; 2) MIB; or 3) any other person or entity who performs business or legal services in connection with the application for or administration of my insurance coverage. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be redisclosed, however the Company contractually requires them to protect the information we disclose to them. Information may be disclosed as allowed by law or regulation.

I understand this consent may be revoked in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my policy with that Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months (12 months in Kansas) from the date of signing. To initiate revocation of this Authorization direct all correspondence to the address above.

I understand that if I refuse to sign this Authorization to release my complete medical records that medical treatment cannot be withheld. However, if I refuse to sign this authorization, the company may not be able to process my application for insurance.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I agree that a copy of the Authorization shall be as valid as the original. I may have a copy upon request.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

I understand the entries made in the Vendor Use box below do not alter this authorization.

SIGNATURE: _____ DATE: _____

Proposed insured/patient or legal representative (Next-of-kin or legal guardian to sign only if patient is a minor, legally incompetent, or deceased)

Relationship to proposed insured/patient of personal/legal representative signing for proposed insured/patient:

For Vendor Use Only