

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations that exempt the minimum necessary rules as they apply to life insurance. I (we) authorize West Coast Life Insurance Company (West Coast Life) and its reinsurers to obtain directly through designated third parties and use any information about or relating to me (us) that may affect my (our) insurability. West Coast Life and its reinsurers may obtain and use health and medical information to include all dates of service, including but not limited to information about chart notes, EKG's, drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. West Coast Life and its reinsurers may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance, a claim for insurance benefits, or both. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. The West Coast Life sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to West Coast Life.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to West Coast Life, directly through designated third parties or its agents acting on its behalf; (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation including all satellite facilities and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for West Coast Life. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize West Coast Life to draw and test my (our) blood, and/or oral fluids, and urine as may be necessary to obtain information to be used to underwrite my (our) application for insurance. These tests may include, but are not limited to, tests for cholesterol and related blood lipids, diabetes, liver or kidney disorders, immune disorders (other than HIV/AIDS; reference number 5 below), and the presence of drugs, nicotine, or their metabolites. This authorization does not include genetic testing. Unless otherwise required by law or regulation, West Coast Life may, but is not obligated to, release any of these test results directly to me or to my spouse and life partner.
4. I (we) authorize West Coast Life to release and disclose the information described in paragraphs 1 and 3 to its affiliates, its reinsurers, persons or organizations providing services relating to insurance underwriting for West Coast Life, **MIB**, and as otherwise required by law. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to other insurers if I (we) have applied or apply to the other insurers for insurance. West Coast Life may release and disclose the information described in paragraphs 1 and 3 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for West Coast Life's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
5. **SPECIAL REQUIREMENT FOR HIV/AIDS TESTING.** If West Coast Life intends to test for the presence of antibodies to the Human Immunodeficiency Virus (HIV), which is the virus that has been associated with Acquired Immune Deficiency Syndrome (AIDS), West Coast Life may require me (us) to authorize that testing separately. I (we) hereby authorize West Coast Life to obtain and use the results of any HIV tests that I (we) separately authorize, and if permitted by law, to disclose the results of those tests to its reinsurers and **MIB**.
6. This authorization shall be valid for 12 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
7. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 5 by writing to West Coast Life at P.O. Box 830570 • Birmingham, AL 35283.
If this authorization is revoked, this would result in the file being closed and no coverage provided.
8. ☐ I (we) have been given a copy of this authorization form and West Coast Life's Description of Information Practices.
☐ I (we) would like to be interviewed if an investigative consumer report will be made. *(Please check if you wish to be interviewed.)*
☐ If performed, I (we) would like copies of my (our) blood profile test results.
9. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act (**HIPAA**) and that the information would then no longer be protected by **HIPAA** and any related regulations.
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. Any modifications to this authorization may preclude our ability to process this application.
10. I understand I do not have to sign this authorization in order to obtain **health care benefits (treatment, payment or enrollment)**.

THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION AND RETURNED WITH THE APPLICATION BEFORE PROCESSING.

Proposed Insured 1 (Signature)		Date of Birth	Date of Authorization: _____ When applicable, print name(s) of minor(s) below:
Print Name		Social Security #	
Proposed Insured 2 (Signature)		Date of Birth	
Print Name		Social Security #	Health Care Provider
Parent or Legal Guardian (Signature)			Physician Name
			Physician Name