Liberty Bankers™
Insurance Group | American Benefit Life

American Benefit Life Insurance Company

1-833-504-0331
LBIG.com

Health Information Authorization

- Please read these statements carefully. Print clearly using blue or black ink.
- This is a HIPAA required authorization.
- Applicant/Insured must submit a completed, signed copy to the administrative office.
- Applicant/Insured should keep a copy for their records.

Applicant/Insured Declarations

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about my past, present or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to, my prescription history, diagnoses and treatment for illnesses, HIV or AIDS, sexually transmitted diseases, medical conditions, mental illness, substance abuse and tobacco use, but excluding psychotherapy notes.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: American Benefit Life Insurance Company for purposes of compliance with the Health Insurance Portability and Accountability Act ("HIPAA"). American Benefit Life Insurance Company will share Protected Health Information ("PHI") with each other for the treatment, payment and health care operations of the American Benefit Life Insurance Company and as permitted by HIPAA and this authorization; American Benefit Life Insurance Company's insurance support organizations and reinsurers; providers, treatment facilities, insurers, pharmacies, pharmacy benefit managers and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, mental health and substance abuse counselors and other health professionals; treatment facilities including hospitals, clinics, substance abuse treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities, reinsurers, other insurance companies and consumer reporting agencies.

Purpose: This health information may be used or disclosed to evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of American Benefit Life Insurance Company's plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization is valid for 24 months from the date signed; (3) if I do not sign this Authorization or I revoke it by writing to American Benefit Life Insurance Company at its administrative office, my application may be declined; (4) if I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (5) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant/Insured complete this section.

Applicant/Insured's signature **Date**

X •

Printed name of Applicant/Insured

X

City **State** **Zip**

• • •

Insured's Policy Number *(if known)*

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