AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health information exchange, health plan, health insurance plan, health care provider or health care facility, health care professional, clinic, laboratory, medical facility, governmental agency, any insurance company or any other entity that has any diagnosis, prescription or other medical information about me, to disclose my entire medical record and any other protected health information including, the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, alcohol, drugs, and tobacco to Tier One Insurance Company or its reinsurers, employees, or representatives ("Tier One"). This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I also authorize MIB, Inc. ("MIB"), and any MIB member insurer, to provide my medical or personal information to Tier One, its reinsurer or any MIB-authorized third-party administrator performing underwriting services for Tier One. I also authorize Tier One, its reinsurer or authorized third-party administrator, to make a brief report of my personal or protected health information to MIB. I authorize any consumer reporting agency to release any credit reports, occupation or travel history, or driving record of mine to Tier One, its agents, employees and representatives.

Tier One and its affiliates may use and disclose information received under these authorizations where required to underwrite your application or if not required, for insurance related operations, except for MIB information, to obtain reinsurance and for any purposes described in this consent. Tier One may disclose my information to data brokers and other data sources, to obtain information about my activities. Tier One may use and analyze this information for any purposes permitted by law, including general underwriting and insurance purposes, improving products and services, enhancing account administration, internal risk controls, fraud detection, product research and development, and marketing.

These authorizations shall be valid for 30 months from this date, or the time limit permitted by law in the state where the policy is issued. You may revoke this authorization at any time, subject to the rights of an individual who acted in reliance on the authorization prior to the notice of revocation, by sending written notice to Tier One Insurance Company, P.O. Box 14863 Lexington, KY 40512-4863. Except for the MIB information, Tier One may use your information for an unlimited period for general underwriting and insurance purposes and to improve the products and services.

By providing my signature, I acknowledge that I have read or been read and agree to the authorizations above, and that I have read or been read and agree to this Authorization for Release of Personal and Medical Information.

Name of Proposed Insured	Date of Birth (mm/dd/yyyy)

Signature	Date

Address of Proposed Insured – street, city, state, zip	
,	, ,

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: Tier One Insurance Company
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

<u>Primary</u> Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address: , , ,		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to <u>Primary</u> Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize Tier One Insurance Company, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that Aflac has taken action in reliance on this authorization. My revocation must be submitted in writing to [Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

______________________________ ______________________________

Signature of Individual Subject to Disclosure | Date Signed

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

______________________________ ______________________________

Printed Name of Legal/Personal Representative | Legal Relationship *(e.g. Power of Attorney)*

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Tier One Insurance Company
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address: , , ,		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize the following to give information (as defined below) to Tier One Insurance Company, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, electronic health record service, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

I understand that any disclosure of health information to Aflac for the purpose of determining eligibility for coverage other than health plan coverage means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that this information will be used by Aflac for enrollment or to determine eligibility for insurance or for underwriting or risk rating (where applicable) purposes and, should coverage be issued, the information may be used to contest a claim for benefits or the issuance of the policy itself during the contestability period provided in the policy.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

I understand that I may revoke this authorization at any time, except to the extent that (1) Aflac has taken action in reliance on this authorization, or (2) other law provides Aflac with the right to contest a claim under the policy or the policy itself. My revocation must be submitted in writing to [Aflac, Policy Service, 1932 Wynnton Road, Columbus, Georgia 31999].

Unless otherwise revoked, I agree that this authorization will expire on the earlier of the date Aflac notifies me of its declination of my application for coverage or, if a policy is issued, two years from the date this authorization is signed.

I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

Signature of Individual Subject to Disclosure Date Signed

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Printed Name of Legal/Personal Representative Legal Relationship *(e.g. Power of Attorney)*

AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health information exchange, health plan, health insurance plan, health care provider or health care facility, health care professional, clinic, laboratory, medical facility, governmental agency, any insurance company or any other entity that has any diagnosis, prescription or other medical information about me, to disclose my entire medical record and any other protected health information including, the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, alcohol, drugs, and tobacco to Tier One Insurance Company or its reinsurers, employees, or representatives ("Tier One"). This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I also authorize MIB, Inc. ("MIB"), and any MIB member insurer, to provide my medical or personal information to Tier One, its reinsurer or any MIB-authorized third-party administrator performing underwriting services for Tier One. I also authorize Tier One, its reinsurer or authorized third-party administrator, to make a brief report of my personal or protected health information to MIB. I authorize any consumer reporting agency to release any credit reports, occupation or travel history, or driving record of mine to Tier One, its agents, employees and representatives.

Tier One and its affiliates may use and disclose information received under these authorizations where required to underwrite your application or if not required, for insurance related operations, except for MIB information, to obtain reinsurance and for any purposes described in this consent. Tier One may disclose my information to data brokers and other data sources, to obtain information about my activities. Tier One may use and analyze this information for any purposes permitted by law, including general underwriting and insurance purposes, improving products and services, enhancing account administration, internal risk controls, fraud detection, product research and development, and marketing.

These authorizations shall be valid for 30 months from this date, or the time limit permitted by law in the state where the policy is issued. You may revoke this authorization at any time, subject to the rights of an individual who acted in reliance on the authorization prior to the notice of revocation, by sending written notice to Tier One Insurance Company, P.O. Box 14863 Lexington, KY 40512-4863. Except for the MIB information, Tier One may use your information for an unlimited period for general underwriting and insurance purposes and to improve the products and services.

By providing my signature, I acknowledge that I have read or been read and agree to the authorizations above, and that I have read or been read and agree to this Authorization for Release of Personal and Medical Information.

Name of Proposed Insured	Date of Birth (mm/dd/yyyy)

Signature	Date

Address of Proposed Insured – street, city, state, zip	
,	, ,

AUTHORIZATION TO DISCLOSE INFORMATION

MAIL TO: Tier One Insurance Company
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address: , , ,		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize Tier One Insurance Company, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac") to make a brief report of my personal health information to MIB, Inc. (formerly known as the Medical Information Bureau).

I understand that this information will be used by MIB, Inc. for the purpose of assisting the insurance industry in the accurate underwriting of insurance products as well as assisting the insurance industry in facilitating the fair pricing of insurance products through more accurate risk assessment.

"Information" includes information in Aflac's possession relating to my physical or mental health or condition (excluding psychotherapy notes, but including, for example, medical diagnosis/treatment information related to underwriting), and nonmedical financial information (including, for example, policy status).

I understand that any disclosure of health information to MIB, Inc. means the information may no longer be protected by federal privacy regulations. I further understand, however, that such information may be redisclosed only in accordance with other applicable laws or regulations.

I understand that Aflac is conditioning the issuance of coverage on the provision of this authorization, and that, while I may refuse to sign this authorization, my refusal to do so could result in coverage not being issued.

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I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

____ ____

Signature of Individual Subject to Disclosure Date Signed

If this authorization has been signed by a personal representative on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

____ ____

Printed Name of Legal/Personal Representative Legal Relationship *(e.g. Power of Attorney)*

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Tier One Insurance Company
[1932 Wynnton Road
Columbus, Georgia 31999-0001]

Primary Policyholder's Name:	**SSN**(optional):	**Date of Birth:**
Policy Number(s):		
Address: , , ,		
Name of Individual Subject to Disclosure (if not the primary policyholder):		**Date of Birth:**
Relationship to Primary Policyholder: □ Self □ Spouse □ Domestic Partner		

I authorize the following to give information (as defined below) to Tier One Insurance Company, American Family Life Assurance Company of Columbus, American Family Life Assurance Company of New York, and Continental American Insurance Company (collectively, "Aflac"): any medical professional, medical care institution, electronic health record service, pharmacy-related service organizations, insurer (including Aflac, with respect to other Aflac coverages), reinsurer, government agency (including departments of public safety and motor vehicle departments), MIB, Inc. (formerly known as the Medical Information Bureau), consumer reporting agency, or employer.

"Information" includes facts or opinions relating to my past, present, or future physical or mental health or condition (excluding psychotherapy notes), employment, other insurance coverage, driving record, or any other medical or nonmedical facts that are required as part of the underwriting process in order to determine eligibility for insurance or to evaluate a claim for benefits during the time this authorization is valid.

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