To be obtained before insurance is issued

Authorization for medical and other confidential information

Conforms to HIPAA privacy rule

1. MY INFORMATION—the individual who is the subject of the information

Name (print full name) ________ Date of birth ________ Social Security number ________

Address ________ City ________ State ________ ZIP code ________

2. DISCLOSING PARTY—the party or parties authorized to release information about me

Any physician or other health care provider, hospital, clinic, medical facility, clinical lab, pharmacy, pharmacy benefit manager or pharmacy-related organization, insurance company or health plan, Social Security Administration, governmental agency, MIB Inc., employer or consumer credit reporting organization

3. DESCRIPTION OF MY INFORMATION AUTHORIZED FOR RELEASE

Any/all information related to my past, present or future health condition(s), medical care/treatment or prescription drug history, which includes information about mental health (excluding psychotherapy notes), communicable disease, HIV/AIDS, alcohol and substance abuse; as well as information contained in a consumer credit or investigative credit report including credit, motor vehicle and criminal records

4. PURPOSE OF AUTHORIZATION—how my information will be used by the receiving party

To determine my eligibility for coverage, and administer benefits under a policy or certificate of insurance

5. DURATION OF AUTHORIZATION

Twenty-four (24) months from the date written below

6. RECEIVING PARTY—the party authorized to receive information about me

Washington National Insurance Company, its agents, representatives and reinsurers and MIB, Inc.

7. CONSENT TO PROVIDE MIB REPORT FOR FRAUD PREVENTION AND DETECTION

I authorize Washington National Insurance Company or its reinsurers to disclose protected health information about me to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and detection program.

8. IMPORTANT INFORMATION—review carefully before signing

- This authorization is required to determine my eligibility for coverage and benefits under a policy or certificate of insurance.
- Refusing to sign this authorization does not affect my ability to obtain medical treatment, but may prevent coverage from being issued or being able to determine when benefits are payable under the terms of my coverage.
- This authorization may be revoked at any time unless it was already relied upon. (Send a written revocation to: Washington National Insurance Company, P.O. Box 2024, Carmel, IN 46082-2024.)
- Washington National Insurance Company is subject to federal privacy laws. However, if I authorize parties who are not subject to these laws to receive medical information about me, then such information could be re-disclosed and would no longer be protected.
- I understand that I (or my authorized representative) have a right to a copy of this authorization, and that a photocopy or facsimile is as valid as the original.

9. APPROVAL—this authorization is not valid until it is signed and dated by me or my legal representative*

Signature ________ Date ________

Print name ________ Relationship (if signed by legal representative*) ________

**Legal representatives must provide documentation of legal authority*

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MEDAUTH-FORM-PRE

WHITE: Home office copy • YELLOW: Applicant copy