EquiTrust®
Life Insurance Company

AUTHORIZATION FOR DISCLOSURE OF PERSONAL INFORMATION

Proposed Insured: _____ **Policy Number:** _____

Applicant/Policy Owner: _____

I, _____, hereby authorize EquiTrust Life Insurance Company hereinafter referred to as "the Company", to disclose my personal information as described below.

Description of Information to be Disclosed:

The Company is authorized to disclose medical information related to my mental health care (excluding psychotherapy notes) and physical health, lab results, developmental disability care, and drug and alcohol abuse treatment for the purpose identified below. I further understand and acknowledge that the information authorized for disclosure may include records which may indicate the presence of a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

For the Purpose of (select all that apply):

☐ ***policy administration*** at my request.

☐ ***processing my claim*** for benefits at my request.

☐ ***obtaining underwriting information*** at my request.

Person or Business Authorized to Receive Information

Name: _____ Relationship: _____ Contact Number: _____

Name: _____ Relationship: _____ Contact Number: _____

Expiration of Authorization

The authorization will expire 24 months from the date of your signature. A copy of this Authorization will be valid as the original.

Signatures

_____ _____
Claimant, Insured, Proposed Insured or Legal Representative — Date

_____ _____
Daytime Phone Number of Claimant, Insured, Proposed Insured or Legal Representative — State in which this authorization was signed

_____ _____
Witness Signature — Date

Your Rights

- I understand that I may revoke this authorization at any time prior to its expiration date by notifying us in writing at the address below, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information that the Company took before it received the revocation.
- The Company may not condition eligibility for benefits on my refusal to sign this authorization.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by the federal and state privacy laws.
- By signing this form, I agree to the disclosure of my medical information to the person or business listed above and I relieve EquiTrust Life Insurance Company from all liability having to do with that disclosure.
- I am entitled to a copy of this authorization form.

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