

**AUTHORIZATION**

## THIS IS A HIPAA COMPLIANT AUTHORIZATION

EquiTrust Life Insurance Company (“the Company”) or its reinsurers may obtain information about me or my minor children from: any physician, medical professional, hospital, medical care facility, government agency, public records, employer, insurance company or institution, consumer reporting agency, pharmacies, pharmacy benefit managers, or MIB, Inc. The purpose is to determine eligibility for insurance or benefits. The Company or its reinsurers may obtain personal information and any records available as to diagnosis, care, treatment and prognosis of any physical or mental condition, and/or prescription drug information, and may obtain an investigative consumer report.

To facilitate rapid submission of such information, all sources, except MIB, Inc., are authorized to give such information or records to any entity designated by the Company or its reinsurers to collect and transmit such information.

This Authorization includes information about mental health care (other than psychotherapy notes), developmental disability care, and drug and alcohol abuse treatment. I understand that: (1) I can revoke this Authorization at any time by written notice to the Company; (2) revocation of this Authorization will not affect any prior action taken by the Company in reliance upon this Authorization; and (3) failure to sign, or revocation of this Authorization may impair the Company’s ability to process applications or evaluate claims and may be a basis for denying this Application or a claim for benefits.

I further understand and acknowledge that the information authorized for release 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).

The Company may disclose information to: its reinsurers, those who perform services for the Company or its reinsurers, those companies to which I have applied or may apply for life or health insurance or benefits, and the Company’s affiliates for claims handling, servicing, underwriting, insurance marketing, and other purposes. Disclosure may also be made when required or permitted by law. Some of the health information noted above 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 understand that I have the right to see personal information collected about me, and have the right to correct any information which may be wrong. I understand that I may obtain a description of this Company’s information practices by requesting one from my agent of the Company at the address provided with my Policy.

This Authorization is valid for 24 months from the date signed. A copy of this Authorization will be valid as the original.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_