Authorization for Release of Health Information to:
Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447
877-777-8808

I/you authorize any: health care provider; hospital; clinic; laboratory; pharmacy; or any other organization, institution, or person that has knowledge or records of me and my health to disclose any and all health information concerning me, up to and including my entire medical record. This includes information about my mental health; any STDs; diagnosis or treatment of Human Immunodeficiency Virus (HIV); substance and or alcohol use, or any other non-health history to be released. I/you authorize the release of such records to Senior Life Insurance Company and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.

I/you authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to Senior Life Insurance Company or its reinsurer . I/you also authorize Senior Life Insurance Company or its reinsurer, to make a brief report of my personal health information to MIB, Inc.

The records being released will be used to determine eligibility for insurance. There is a possibility that the records provided will be re-disclosed. If the records are disclosed, they may no longer be protected by federal rules governing privacy and confidentiality. This authorization will be valid for twenty-four (24) months from the date the authorization is signed. You may revoke this authorization at any time by sending a written request to us at the address shown above. If I revoke this authorization, the rights of any individual who used my records based on my authorization, prior to receiving notice of my revocation, will not be affected. I can refuse to sign this authorization. If I do not sign, my application may not be accepted, or my claim may be denied.

Policy Number

Proposed Insured's Printed Name | Date of Birth | Social Security Number

Proposed Insured's Signature | Date

Authorized Representative's Signature | Relation to Insured | Date