EPIC SPECIALTY BENEFITS

The EPIC Life Insurance Company
1717 W. Broadway | P.O. Box 8430 | Madison, WI 53708-8430
800-520-5750

Authorization to Disclose Health-Related Information

(This Authorization Complies with the HIPAA Privacy Rule)

_____ _____

Claimant Full Name | Date of Birth

I authorize any physician, healthcare professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility or provider, clearinghouse, health plan, insurance or reinsuring company, agent, broker, service provider, credit bureau or other consumer reporting agency, employer, the Veterans Administration, the Medical Information Bureau, Inc., or any other personal or business associate to disclose any and all "Information" about me to The EPIC Life Insurance Company, its employees, agents or representatives ("EPIC Specialty Benefits"). "Information" may include my entire medical record (including records created after the date of my signature), diagnosis, prognosis, prescription history, medicines prescribed, treatment or care of any physical or mental condition concerning me, including information about HIV/AIDS, drug or alcohol abuse or mental illness (excluding psychotherapy notes), and/or financial, consumer report, or any other medical or non-medical information about me.

The Information to be disclosed under this Authorization may be used by EPIC Specialty Benefits to: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities relating to any coverage I have or have applied for with EPIC Specialty Benefits.

I understand that I have the right to revoke this Authorization at any time by providing written notice of revocation to EPIC Specialty Benefits. I am aware that my revocation will not be effective until received by EPIC Specialty Benefits and will not be effective regarding the uses and/or disclosures of my Information that EPIC Specialty Benefits has made prior to receipt of my revocation. If the authorization was obtained as a condition of obtaining insurance coverage, other law provides EPIC Specialty Benefits with the right to contest a claim under the policy or the policy itself. A copy of this form shall be as valid as the original.

I understand that I am under no obligation to sign this Authorization but that my refusal to sign it may prevent EPIC Specialty Benefits from being able to process my application for coverage, determine my eligibility or make benefit payments. My physician or other health care provider may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization, it may no longer be protected by federal privacy rules and may be re-disclosed by the person or entity that receives it. I am entitled to keep a copy of this form for my records. This Authorization shall expire 30 months from the date signed.

_____ _____

Signature of Claimant | Date Signed

_____ _____

Name of Personal Representative* | Signature of Personal Representative*

*Personal Representative's Authority or Relationship to Claimant (attach any supporting documentation)