



Authorization for Release and Disclosure of Health Information
(This Authorization Form Is In Compliance With All HIPAA Privacy Rules and Regulations)

I hereby authorize any Critical Illness, Disability, Life, Health, Long-Term Care and Annuity insurance company, their Re-Insurers, insurance support organizations such as Medical Information Bureau, Inc. and/or consumer reporting agencies, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf (herein referred to as “My Providers”) to disclose my entire medical record and any other protected health information concerning me to The Ark Group, its employees and those persons or entities providing services to The Ark Group. This includes but is not limited to information on the diagnosis or treatment of: Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, mental illness (psychotherapy notes excluded), the use of alcohol, drugs and/or tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I further instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information shall be disclosed under this authorization so that The Ark Group may:

1. Assist in the underwriting of my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2. Assist in obtaining reinsurance;
3. Conduct other legally permissible activities that relate to any coverage I have or have applied for.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request to: The Ark Group, ATTN: New Business Dept., 1055 N. 115th St., Suite 200, Omaha, Nebraska, 68154. I further understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any information disclosed pursuant to their authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand and accept that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical records, The Ark Group may not be able to process my application properly. I acknowledge that I will receive a copy of this authorization upon my request.

Printed Name of Proposed Insured

Date of Birth

Signature of Proposed Insured

Date

Description of Representative Agent’s Authority/Relationship to Proposed Insured

Printed Name of Agent

Signature of Agent