HOME OFFICE:
7633 East 63rd Place, Suite 230
Tulsa, OK 74133
(918) 249-2438

ADMINISTRATIVE OFFICE
PO BOX 5205
Frankfort, KY 40602-5205
Phone: (866) 440-1357
ax: (502) 875-7084

FAMILY BENEFIT LIFE INSURANCE CO.

MEDICAL AND CONSUMER REPORTS AUTHORIZATION

Name of Proposed Insured/Patient	Date of Birth Month / Day / Year	Social Security Number	Policy Number (if known)

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE:

I authorize any health plan, physician, health care professional, hospital, Veterans Administration, medical care facility, health care provider, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsurance company, insurance support organization (such as MIB, LLC.), consumer reporting agency, state Motor Vehicle Departments, or public records holder, or other provider that has provided treatment or services to me or on my behalf within the past 10 years (collectively, "My Providers") to disclose information about me, including but not limited to, my entire medical record, medication history, or any other protected health or consumer information to Family Benefit Life Insurance Company ("the Company"), its agents, employees, representatives, reinsurers, or any MIB-authorized third-party administrator performing services on the Company's behalf.

I understand the Company, its reinsurers, or any MIB-Authorized third-party administrator performing services on the Company's behalf may re-disclose any information pursuant to this authorization, including the reporting of protected health information or personally identifiable information to MIB, LLC.

This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STDs). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

This information is to be disclosed under this Authorization so that the Company may: (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 that relate to any coverage I have or have applied for with the Company.

I agree that a copy of this authorization, or my recorded voice or electronic authorization, is as valid as the original. This authorization shall remain in force for 36 months (or a shorter time period if required by applicable state law) following the date of my signature below, regardless of my condition and whether living or deceased. A copy of this authorization is as 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 for revocation to the Company, 7633 East 63rd Place, Suite 230, Tulsa, OK 74133 Attn: General Counsel. I understand that a revocation is not effective to the extent that any of My Providers has already 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 understand that any information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal rules governing privacy and confidentiality of health information. However, the Company will protect the privacy of health information in accordance with other applicable state and federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that my authorized representative or I am entitled to a copy of this signed authorization.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient
(For death claims, please attach copy of appointment of executor of estate.)