



AUTHORIZATION: I (the undersigned) authorize any physician, medical professional, medical facility, pharmacy benefit manager, insurer, reinsurer, consumer reporting agency or the Medical Information Bureau (MIB) to release information from the records of:

1. Applicant/Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security Number: _____

This Authorization covers any periods of medical treatment during the last seven years.

- 2. Information to be released: My complete medical records including:
- information about the diagnosis, treatment or prognosis of my medical condition (including referral documents from other facilities); and
- prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources.
3. Information is to be released to: EMSI (Examination Management Services Incorporated), Jefferson Pilot Financial Insurance Company or its reinsurers.
4. I understand that the purpose of disclosing this information is to evaluate my application for insurance. The Company will use the information obtained with this Authorization to determine eligibility for insurance; and will only release such information:
- to reinsurance companies, the MIB or providers of a business or legal service concerned with my application; and
- as otherwise may be required by law or may be further authorized by me.

I further understand that refusal to sign this Authorization may result in denial of eligibility for this insurance coverage.

- 5. I understand the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law, however, the Company contractually requires the recipient to protect the information.
6. I understand that I may revoke this Authorization in writing at any time, except to the extent: 1) the Company has taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim under my coverage with the Company. If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of signing. To initiate revocation of this Authorization, direct all correspondence to the Company at the above address.
7. A photocopy of this Authorization is to be considered as valid as the original.
8. I acknowledge that I have received the attached Notice of Information Practices.
9. I understand that I am entitled to receive a copy of this Authorization.

Signature of Applicant: _____ Date: _____

PRINT COPY FOR YOUR RECORDS

NOTICE OF INSURANCE INFORMATION PRACTICES

COLLECTION OF INFORMATION

This NOTICE is provided in compliance with your state's Insurance Information and Privacy Protection Act.

In order to provide insurance coverage on a fair and equitable basis, we must collect information about you and others for whom coverage may be provided. This information may include age, occupation, physical condition, health history, prescription drug records, general reputation, mode of living and other personal characteristics.

You will provide much of the information. We may collect or verify information by personal interviews and by otherwise contacting Medical professionals and institutions, pharmacy benefit managers, employers, business associates, friends, neighbors and other insurance companies. We may ask insurance support organizations to collect information and submit an investigative consumer report. That organization may disclose the contents of the report to others for which it performs such services. You may request a copy of the report or a personal interview in connection with it.

DISCLOSURE OF INFORMATION

The law allows disclosure of certain information without your authorization in response to a valid administration or judicial order, as permitted or required by law, or to:

1. Persons or organizations performing professional, business or insurance functions for us;
2. Our agents, insurance support organizations or consumer reporting agencies;
3. Medical professionals and medical-care institutions;
4. Persons or organizations conducting bonafide actuarial or scientific research studies, audits or evaluations;
5. Insurance regulatory, law enforcement or other governmental authorities;
6. Persons or organizations involved in any sale, transfer, merger or consolidation of our business; and
7. Group Policyholders, certificate holders, professional peer review organizations, or persons having legal or beneficial interest in a policy of insurance.

We do NOT disclose to our affiliates any information we receive about you from a consumer reporting agency. We do NOT disclose your nonpublic personal information to third parties except as necessary to provide you our products and services.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. We, or our reinsurers, may make a brief report to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. Please contact the MIB at 866 692-6901 (TTY 866 346-3642 for hearing impaired). If you question the accuracy of the information in the MIB's file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB's information office is P. O. Box 105, Essex Station, Boston, MA 02112.

We, or our reinsurers, may also release information in our file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

PERSONAL DISCLOSURE

Also, you have a right to access personal information about you in our files. You may request that we correct, amend or delete information you believe is inaccurate or irrelevant. A description of the appropriate procedures will be sent to you upon written request.

TELEPHONE PERSONAL HISTORY REVIEW

After your application has been received in the Home Office, you may receive a telephone call from a specially trained Home Office Interviewer who will ask you some questions to obtain verification or additional information.

If you have questions about the terms discussed in the NOTICE, please write to:
Jefferson Pilot Financial Insurance Company
P. O. Box 2616
Omaha, Nebraska 68103-2616

DETACH THIS COPY AND KEEP FOR YOUR RECORDS