



Renaissance.

Life & Health Insurance Company of America

Health Administrative Office - P.O. Box 27248 Salt Lake City, Utah 84127-0248 - Phone: 1-844-202-4150

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Renaissance Life & Health Insurance Company of America for the purpose of 1) evaluating my application for insurance; 2) obtaining reinsurance; 3) determining or fulfilling responsibility for coverage and provision of benefits; 4) and administering coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, MIB, Inc., or anyone else to release any and all records and information to be exchanged between Renaissance Life & Health Insurance Company of America and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I authorize Renaissance Life & Health Insurance Company of America, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Renaissance Life & Health Insurance Company of America at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Renaissance Life & Health Insurance Company of America may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Signature of Proposed Insured

Signature of Proposed Insured B

Date

Date

RETURN TO COMPANY