AMERICAN INTEGRITY
LIFE INSURANCE COMPANY

American Integrity Life Insurance Company
PO Box 22805
Hot Springs, AR 71903
Ph: (866) 524-5433 Fx: (888) 332-5144

HEALTH INFORMATION AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has records or knowledge of me or my health to give American Integrity Life Insurance Company, its reinsurers or its affiliates any such information. I understand that I am authorizing American Integrity Life Insurance Company to receive my health information and prescription drug usage history. The released information received by American Integrity Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the company. Any information that is disclosed pursuant to this authorization may be re disclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that the information required is necessary for evaluation and underwriting of my application for the Life Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefit; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with American Integrity Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide this authorization to American Integrity Life Insurance Company will result in the rejection of the Life Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying American Integrity Life Insurance Company at their Administrative Office: PO Box 22805, Hot Springs, AR 71903-22805. I understand that such revocation will not have any effect on actions American Integrity Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative is entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Life Insurance coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing . I certify that I have read, or have had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

I understand that no Agent or Broker is authorized to accept risks or pass upon insurability, to make or modify contracts, or to waive any of American Integrity Life Insurance Company's rights, conditions, or requirements. Only an authorized officer of American Integrity Life Insurance Company can do this.

I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I am not being paid cash and have not been promised services as an inducement to enter into this application. This purpose of this application is not to sell or assign it to any type of viatical settlement, senior settlement or life Settlement Company.

I understand that any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I acknowledge receipt of a copy of the Fair Credit Reporting Act and MIB, Inc. Notices. I authorize American Integrity Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. 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 instruct any Medical Provider to release and disclose my entire medical record without restriction. Protected Medical Information: Any and all records and health information within such Medical Person's possession such as medical history, entire medical records, mental, psychiatric (excluding psychotherapy notes) and physical condition, prescription drug records, tobacco, drug and alcohol use and any other protected healthy information concerning me. This includes information which may be considered to be a communicable or a sexually transmitted disease, which may include, but not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).

This authorization is valid for 24 months from the date signed.

Primary Physician’s Name	Address (U.S. physician required)	Phone Number
Applicant's Signature	Applicant's Printed Name	Date Signed (mm/dd/yyyy)
Witness (Agent) Signature	Producer's Printed Name	Date Signed (mm/dd/yyyy)