



Administrative Office: P O Box 224
Brownwood, Texas 76804
1-800-604-8002

AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: medical practitioner, physician, hospital, clinic, pharmacy benefit manager, or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the MIB, Inc., the Department of Motor Vehicle Registration, and paramedical facility to provide to LIBERTY BANKERS LIFE INSURANCE COMPANY, or to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on LIBERTY BANKERS LIFE INSURANCE COMPANY'S or its reinsurers' behalf, information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the applicant(s). It is understood that LIBERTY BANKERS LIFE underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I authorize LIBERTY BANKERS LIFE INSURANCE COMPANY, or its reinsurers, to make a brief report of my protected health information to the MIB, Inc.

I understand that:

- such information will be used by LIBERTY BANKERS LIFE INSURANCE COMPANY for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain life insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Life Underwriting Department of LIBERTY BANKERS LIFE INSURANCE COMPANY, P. O. Box 224, Brownwood, Texas 76804. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Date

Proposed Insured (Please print)

Signature of Proposed Insured (or parent if Proposed Insured is under age 16)

Birthdate

Additional Proposed Insured (Please print)

Signature of Additional Person Proposed for Insurance

Birthdate

Personal Representative designated by signature above is hereby authorized to execute this instrument based on:
power of attorney, guardian-in-fact, guardian, payee,
representative, other _____(Circle one)