American Fidelity Assurance Company

2000 N Classen Boulevard Oklahoma City, Oklahoma 73106

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize the entities specified below to disclose any information about me or my dependents' health including my or my dependents' entire medical record, except psychotherapy notes, to individuals representing American Fidelity Assurance Company (AFAC) who are involved in processing my application or determining my eligibility for coverage for the purpose of determining eligibility in the insurance coverage(s) for which I have applied and to check for and resolve any issues that may arise regarding incomplete or incorrect information on my application. Those so authorized are: a) licensed physicians or medical practitioners; b) hospitals, clinics or medically-related facilities; c) health plans; d) Veteran's Administration; e) past or present employers; f) consumer reporting agencies; g) insurance companies; h) the Medical Information Bureau (MIB); and i) Department of Motor Vehicles. Colorado state law prohibits the redisclosure or reuse of information disclosed about a Colorado resident under this authorization.

NOTICE: Information authorized for release may include information on communicable or venereal diseases such as hepatitis, syphilis, gonorrhea, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome) or other conditions for which you may have been treated. For Minnesota residents, please be advised that although the law allows insurance companies to obtain information about an HIV test, there are specific instances wherein the insurance company cannot ask whether the person has had an HIV test performed. In those specific circumstances, this law also restricts the use of HIV test results in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate or contract. For Vermont residents, this authorization EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing AFAC to forward the results from any new test requested by AFAC to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services. Nothing in this release authorizes the disclosure of data regarding AIDS, ARC or HIV. For Wisconsin residents, results of AIDS/HIV tests do not need to be reported if they were done at an anonymous counseling and testing site, if the test was not an FDA-licensed blood test, or through the use of a home test kit.

I understand that I may refuse to sign this authorization; however, if I do not sign the authorization, AFAC may refuse to issue insurance coverage. I understand that I may revoke this authorization at any time by writing to Privacy Official, American Fidelity Assurance Company, PO Box 25523, 2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73125, or by calling, toll-free, 1-866-55-HIPAA. I understand that my right to revoke this authorization is limited to the extent that: AFAC has taken action in reliance on the authorization; or, the law provides AFAC with the right to contest my insurance coverage or a claim under my insurance coverage.

I understand that if protected health information is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

This authorization will expire twenty-four months from the date shown below. For Arizona residents, release of HIV/AIDS-related information can only be disclosed for a period not to exceed 180 days from the date shown below. A copy of this authorization will be as valid as the original. I am aware that I, or my authorized representative, am entitled to and will receive a copy of this authorization.

Signature (Applicant) or Personal Representative (if applicable)	Printed Name (Applicant)
Relationship of Personal Representative to Applicant	SSN (Applicant) Date