AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

P.O. Box 1650
Little Rock, AR 72203-1650
Telephone: (800) 370-5856
E-mail: claims@usablelife.com

I hereby request and authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, healthcare clearinghouse, insurance company, reinsurer, the Medical Information Bureau ("MIB") or consumer reporting agency ("providers") that has provided payment, treatment or services to me and any member of my family who has filed a claim ("family member"), or other person on whose behalf I am acting, to disclose the entire medical record and any other protected health information concerning me and any family member to USAble Life and its agents, employees, legal representatives, reinsurers, and the MIB. This includes information on the diagnosis of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict protected health information do not apply to this authorization, and I instruct any providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that USAble Life may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage I or any family member, or other person whom I represent has or has applied for with USAble Life.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I or my family member, or other person whom I represent has the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Customer Service, USAble Life, PO Box 1650, Little Rock, AR 72203-1650, or to custserv@usablelife.com. I understand that a revocation is not effective to the extent that any of the providers have relied on this authorization or to the extent that USAble Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the providers may not refuse to provide treatment if I refuse to sign this authorization. However, I further understand that if I refuse to sign this authorization to release complete medical records, USAble Life may deny my claim for benefits. I acknowledge that I have received a copy of this authorization.

_____ _____
Claimant's Name (please print) Date

_____
Claimant's Signature – Parent/ Guardian if Minor

Return original with your claim & retain a copy of this authorization and claim form for your records.