Authorization for release of health-related information

8300 Mills Civic Pkwy, West Des Moines, IA 50226-3822

This authorization complies with the HIPAA privacy rules.

Name of proposed insured (please print first name, last name)	Date of birth (mm/dd/yyyy)

I authorize any health plan, physician, dental practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record and any other protected health information concerning me to Midland National® Life Insurance Company (Midland National) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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 my providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Midland National may:
1) underwrite my application for coverage, determine eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Midland National.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Midland National at PO Box 10385, Des Moines, IA, 50306-0385, Attention: Client Services. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that Midland National has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that my providers cannot deny me treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I alter, revoke, or refuse to sign this authorization to release my complete medical record, Midland National may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge by my signature below, that I have a right to receive, and have in fact received, a copy of this authorization.

Signature of proposed insured or personal representative	Date (mm/dd/yyyy)

If you are the personal representative of the proposed insured, describe the scope and/or basis of your authority to act on the insured's behalf:

Send original with application – give a copy to proposed insured.

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AGENT INSTRUCTION: Two copies needed.
Return this signed original to the Home Office, leave a signed copy with the proposed insured.