SOUTHWEST SERVICE LIFE INSURANCE CO.

IMPORTANT NOTICE

This Medical Records Authorization Form must be completed, signed and submitted with the initial application.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANT MEDICAL RECORDS AUTHORIZATION FORM

Patient/Primary Proposed Insured _____

Address: _____ City: _____Zip: _____Date of Birth:____ / ____ / ____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996; 45 CFR §164.508. It authorizes Southwest Service Life Insurance Co. to use my complete medical records, and those of my family members whose names appear in my application for health insurance, for the purposes of insurance underwriting, risk review, claims adjudication and other health plan insurance operations.

The person/people/entities authorized to make this disclosure to Southwest Service Life Insurance Co. is/are my physicians, medical practitioners, hospitals, clinics, medical facilities, the Pharmacy Benefit Manager, or other health care providers having records or knowledge of my health, and those of my family members whose names appear in my application for health insurance.

The confidentiality of my health care information is waived by this authorization, which permits disclosure of any and all requested parts of my medical records. I understand that re-disclosure may not be protected by the federal privacy regulations. I also understand this may include drug, alcohol, mental health, HIV or AIDS information.

This authorization is valid for two years following the date written below and will then expire. Under the Privacy Rules, I have the right to revoke this authorization at any time, and Southwest Service Life Insurance Co. must cease using this authorization. However, Southwest Service Life Insurance Co. may complete any actions it initiated prior to my revocation and which rely on my complete medical records for completion. I must revoke this authorization in writing and send the revocation to Southwest Service Life Insurance Co., P.O. Box 982005, Fort Worth, Texas 76182-8005.

Notice to my health care provider(s): An electronic signature on this HIPAA Compliant Medical Records Authorization Form has the same legal authority as a hand-written signature under both state and federal law. Please accept my e-signature as if it were my original hand-written signature.

Signature of Patient/
Primary Proposed Insured _____ Date ____ / ____ / ____ Date of Birth:____ / ____ / ____

Signature of Patient/Spouse
(if proposed to be insured) _____ Date ____ / ____ / ____ Date of Birth:____ / ____ / ____

Signatures of other
Patients/Dependents 18 or over
(if proposed to be insured)

_____ Date ____ / ____ / ____ Date of Birth:____ / ____ / ____

_____ Date ____ / ____ / ____ Date of Birth:____ / ____ / ____

_____ Date ____ / ____ / ____ Date of Birth:____ / ____ / ____

Please Complete if Applicable:

Print name(s) of covered children

_____ Date of Birth: ____ / ____ / ____

_____ Date of Birth: ____ / ____ / ____

_____ Date of Birth: ____ / ____ / ____