MEDICO®

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

Authorization for the Use and Disclosure of Information

I hereby authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to use and/or disclose the following information about me as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations**.

Policy/Identification Number: _____

_____ ____ /____ /____

Full name of insured whose information is being requested for use/disclosure *Date of Birth*

1. Persons/class of persons authorized to use or make disclosure of the information: **The Company staff with appropriate access clearance to use and disclose the applicable information.**

2. Name and address of persons/class of persons authorized to receive the information: _____

   _____

3. Specific description of information that may be used/disclosed:
   - __ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
   - __ **Personal Information** (such examples may include, but is not limited to, the following: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, employer, prior insurance information, etc.)
   - __ **Bank Information** (such examples may include, but is not limited to, the following: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
   - __ **Coverage Information** (such examples may include, but is not limited to, the following: Effective date, paid-to date, premium amounts, mode of payment, names and policy/certificate provisions specific to covered member(s), medical waiver(s)/rating(s) on coverage, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
   - __ **Other**, please specify: _____

4. The information will be used/disclosed for the following purposes (***all*** purposes must be listed and described):
   - __ **Benefit/Payment Purposes** (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs)
   - __ **Coverage Maintenance** (examples include, but are not limited to, the following: perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment)

(Continued on back)

__ **Coverage Changes** (examples include, but are not limited to, the following: to add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes)
__ **Other**, please specify: _____

5. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. the Company or another third party has taken action in reliance on this authorization; or
   b. this authorization is obtained as a condition for obtaining insurance coverage, as other laws may provide the Company with the right to contest a claim under the policy/certificate or the policy/certificate itself.

   I understand to revoke my authorization I should send my written revocation request to:

   Medico
   Customer Service Center
   P.O. Box 10386
   Des Moines, Iowa 50306-0386

6. This authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

Fill in the information in the following paragraph <u>ONLY</u> if you are completing this authorization as a personal representative of the policy/certificate holder and sign and date the completed form.

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____, that my relationship to the policy/certificate holder is _____, and that I have the lawful authority to enter into this authorization on behalf of the policy/certificate holder. I have read the provisions set forth in this authorization, and agree that the Company and its affiliates may use and/or disclose the aforementioned information for the purposes set forth herein.

Please enclose a copy of the legal document that shows you are a personal representative for the policy/certificate holder when you return this form.

_____ _____
Signature of Individual or Personal Representative *Date*

_____ _____
Printed Name of Individual or Personal Representative *Relationship of Personal Representative or Authority to Act for the Individual*

You will be provided a copy of this signed authorization.