MEDICO®

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

Authorization for the Use and Disclosure of Information – Life Insurance

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:
   __ **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), policy/certificate numbers, insured member(s) date of birth(s), etc.)
   __ **Other**, please specify: _____

4. The information will be used/disclosed for the following purposes (***all*** purposes must be listed and described):
   __ **Cash Value amounts, Beneficiary information and/or Owner information**
   __ **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, other law 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

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Medico Insurance Company administers for Ability Insurance Company
Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company

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.