RESET

PACIFIC GUARDIAN LIFE

# Authorization for Release of Health-Related Information

(This authorization complies with the HIPAA Privacy Rule)

_____ _____

Name of Proposed Insured/Patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, consumer reporting agency, the MIB, Inc. ("MIB") or other health care provider that has provided treatment or services to me ("my Providers") to disclose my entire medical record and pharmaceutical record to Pacific Guardian Life Insurance Company Limited (the "Company"), its employees, authorized agents and representatives, and any insurance support organization acting on the Company's behalf for the purpose of evaluating my application for insurance. 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.

This authorization also authorizes the MIB, any consumer reporting agency, or other insurance support organization or employer having information or records relative to age, character, habits, avocations, finances, occupation, general reputation, credit, other insurance coverage, participation in hazardous activities, of me (us) or my (our) minor children on whom insurance is applied for, to furnish any and all such information to the Company or its reinsurers, agents, and any insurance support organization acting on its behalf for the purpose of evaluating my application for insurance.

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 to the Company.

This protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite my application for coverage, make 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 the Company. I have reviewed the Notice of Insurance Information Practices that is included in my application for insurance and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This authorization will be valid for 30 (24 in Oregon) months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time by giving written notice to the Company at 1440 Kapiolani Boulevard, Suite 1600; Honolulu, HI 96814, Attention: New Business Department. I understand that a revocation is not effective to the extent that any of My Providers have relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company 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 that I have received a copy of this authorization.

_____ _____

Signature of Proposed Insured/Patient (or Personal Representative) Date

_____

Describe Authority of Personal Representative (if applicable)

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