Authorization for Use and Disclosure of Protected Health Information to Philadelphia American Life Insurance Company (PALIC) by Another Entity

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, pharmacy or pharmacy benefit manager that possesses prescription history about me, institution or person, that has any records or knowledge of me and my health, to give PALIC and its reinsurers, any and all such health information. PALIC will use this information for the purpose of making underwriting determinations relating to my request for insurance. PALIC may also use this information in determining my eligibility for claim benefit payments. Health information obtained will not be re-disclosed without your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

I understand that I may revoke this authorization at any time, in writing, unless action has been taken in reliance on this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, however, failure to sign this authorization will cause the application determination process to terminate. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that the information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

This authorization shall remain in effect for the longer of while coverage is in force or thirty (30) months. A photocopy, electronic digital signature or electronic image of this authorization is to be considered as valid as the original. I understand that I can request a copy of this form at any time. I have read this document and understand its information.

______________________________ ____________________
Signature of Applicant *Date*

______________________________ ____________________
Signature of Spouse *Date*