ILLINOIS MUTUAL®
Life Insurance Company

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

This Authorization is intended to comply with the HIPAA Privacy Rule (45 C.F.R. Part 164, Subpart E).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

PURPOSE

Providing this Authorization enables Illinois Mutual Life Insurance Company and its agents, employees, and representatives (collectively, "Illinois Mutual") to underwrite your application and determine your eligibility for coverage, obtain reinsurance, administer coverage issued to or claims made by you, and conduct other legally permitted activities relating to the coverage for which you have applied or that is issued to you. Providing this Authorization is voluntary, but if you decline to provide this Authorization, Illinois Mutual may deny your application for coverage or your claim for benefits.

AUTHORIZATION

I authorize and request:
any health plan, physician, other health care professional or practitioner, clinic, hospital, psychiatric facility or mental health institution, other health care facility or health care provider, laboratory, pharmacy, pharmacy benefit manager, insurance or reinsurance company, viatical broker, provider or company, healthcare clearinghouse, ambulance or other healthcare transport service, MIB LLC, government agency, consumer reporting agency, insurance support organization, third party administrator, and any other organization, institution, or person that has screening, diagnosis, treatment, prescription, or other health or health payment information about me (each, an "Information Source"), to release and disclose to Illinois Mutual, all such screening, diagnosis, treatment, prescription, or other health or health payment information about me, including (a) my entire medical and health care claims records; and (b) any information relating to mental health (other than psychotherapy notes), drug, alcohol or other substance misuse, Human Immunodeficiency Virus ("HIV") infection and other sexually transmitted diseases, and dental and vision health (collectively, my "Personal Health Information"). My Personal Health Information includes any protected health information subject to the HIPAA Privacy Rule.

This Authorization overrides any agreement I may have made with any Information Source to restrict use or disclosure of my Personal Health Information. I instruct Information Sources to release and disclose my Personal Health Information to Illinois Mutual, or its reinsurers, without restriction.

I authorize Illinois Mutual to use and to re-disclose my Personal Health Information for the purpose stated above, including to make a brief report to MIB LLC and to other parties providing services to Illinois Mutual who may be involved with my claim. I understand that Illinois Mutual will not otherwise use or re-disclose my Personal Health Information, except as further authorized by me or as permitted or required by law. I further understand that once my Personal Health Information is redisclosed by Illinois Mutual, it may no longer be protected by Federal or other laws.

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

EXPIRATION AND REVOCATION

Unless I earlier revoke this Authorization by written notice to Illinois Mutual, this Authorization will expire 24 months following the date I enter below (except that it shall remain in force for the duration of the policy in Minnesota; 30 months in Arizona, California, Connecticut, Delaware, Georgia, Illinois, Maine, Massachusetts, Nevada, New Jersey, North Carolina, Ohio and Virginia; 1 year for mental health records in Maine; 1 year for substance abuse records in Alabama; 90 days for Iowa HIV infection and sexually transmitted diseases records; and 180 days for Arizona HIV infection and sexually transmitted diseases records). I understand I may revoke this Authorization at any time by written notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634. I understand that a revocation is not effective to the extent that Illinois Mutual or any Information Source has relied on this Authorization before receiving notice of my revocation, or to the extent Illinois Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself.

ACKNOWLEDGEMENT AND SIGNATURE

I have read this Authorization. I understand that, upon request of Illinois Mutual, I am entitled to a copy of this Authorization bearing my signature or the signature of my personal representative below. I agree that a photocopy or facsimile of this signed Authorization is as valid as the original.

_____ _____

Date

Signature of Proposed Insured or Claimant

_____

Printed Name of Proposed Insured or Claimant

_____

Signature of Personal Representative authorized by law to give this Authorization

_____

Personal Representative's authority or relationship to Proposed Insured or Claimant

_____

Practitioner or Facility (Home Office Use Only)

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

ILLINOIS MUTUAL®
Life Insurance Company

CONSENT FOR DISCLOSURE OF SUBSTANCE USE DISORDER PATIENT RECORDS

This Consent is intended to comply with the Federal Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

PURPOSE

Your provision of this Consent enables Illinois Mutual Life Insurance Company and its agents, employees, and representatives (collectively, "Illinois Mutual") to underwrite your application and determine your eligibility for coverage, obtain reinsurance, administer coverage issued to or claims made by you, and conduct other legally permitted activities relating to the coverage for which you have applied or that is issued to you. Your provision of this Consent is voluntary, but if you decline to provide this Consent, Illinois Mutual may deny your application for coverage or your claim for benefits.

CONSENT

I consent to any substance use disorder program subject to 42 C.F.R. Part 2 that has patient records about me to disclose to Illinois Mutual and its Vice President of Underwriting and/or Vice President of Claims all such patient records, inclusive of any screening, diagnosis, treatment, prescription, or other information, reports and histories about me (collectively, my "Substance Use Disorder Patient Records"). I further consent to any other organization, institution or person that holds my Substance Use Disorder Patient Records to disclose those patient records to Illinois Mutual and its Vice President of Underwriting and/or Vice President of Claims.

I consent to use and re-disclosure of my Substance Use Disorder Patient Records by Illinois Mutual, its reinsurers, and its Vice President of Underwriting and/or Vice President of Claims for the purpose stated above, including making a brief report to MIB LLC, or its reinsurers, with each re-disclosure accompanied by the following notice: "42 CFR part 2 prohibits unauthorized disclosure of these records."

EXPIRATION AND REVOCATION

Unless I earlier revoke this Consent by notice to Illinois Mutual, this Consent will expire 24 months following the date I enter below (1 year for substance abuse records in Alabama). I understand I may revoke this Consent at any time by notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634. I understand that a revocation is not effective to the extent that Illinois Mutual or any lawful holder of my Substance Use Disorder Patient Records has relied on this Consent before receiving notice of my revocation, or to the extent Illinois Mutual has a legal right to contest a claim under an insurance policy or to contest the policy itself.

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

ACKNOWLEDGEMENT AND SIGNATURE

I have read this Consent. I understand that, upon request of Illinois Mutual, I am entitled to a copy of this Consent bearing my signature or the signature of other authorized person identified below. I agree that a photocopy or facsimile of this signed Consent is as valid as the original.

Date

Signature of Proposed Insured or Claimant

Printed Name of Proposed Insured or Claimant

Signature of other person authorized by law to give this Consent

Other person's authority or relationship to Proposed Insured or Claimant

Practitioner or Facility (Home Office Use Only)

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355

ILLINOIS MUTUAL®
Life Insurance Company

CONSENT TO USE AUTOMATED TECHNOLOGY

This Consent is intended to comply with the
Telephone Consumer Protection Act
(47 U.S.C. § 227).

Proposed Insured or Claimant: _____ Date of Birth: _____

Address: _____ Policy/Claim Number: _____

Illinois Mutual Life Insurance Company ("Illinois Mutual") and its representatives use technology that includes automated telephone dialing systems and prerecorded messages ("Automated Technology") to improve the application process for Illinois Mutual insurance products.

I understand I am not required to consent to the use of Automated Technology as a condition of completing the insurance application process or purchasing insurance or other products from Illinois Mutual. Unless I check the box below, I consent to Illinois Mutual and its representatives contacting me for the insurance application process using Automated Technology at any phone number I have provided to or for Illinois Mutual (including a mobile phone number).

☐ I do not consent to Illinois Mutual or its representatives contacting me for the insurance application process using Automated Technology at any phone number I have provided to or for Illinois Mutual.

I understand I may revoke this Consent at any time by written notice of revocation to Compliance Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, Illinois 61634, or by other reasonable means.

_____ _____
Date Signature of Proposed Insured

_____
Printed Name of Proposed Insured

Illinois Mutual Life Insurance Company
300 S.W. Adams Street Peoria, IL 61634 Phone (800) 437-7355