Murfee Meadows, Inc.

Administration and Financial Services

Accordia
American General
American National
AVIVA Life Insurance Co
AXA Equitable Life Insurance
Banner Life Insurance
Canada Life Insurance Company
Cincinnati Life Insurance
Genworth Life Insurance Company
Global Atlantic
Hartford
Life of the Southwest
Lincoln Life and Lincoln Life of NY
Lincoln National
Metlife Investors
Mutual of Omaha
Nationwide
North American Company for Life & Health
Pacific Life
Protective Life
Pruco Life Insurance
Prudential Insurance Company of America
Principal Life Group
Principal National Life Insurance Co
Reliastar Life
John Hancock USA/ John Hancock Life
SBLI
Transamerica
United of Omaha
Voya

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided treatment or services to me or on my behalf (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Murfee Meadows, Inc. (the Company), its affiliates or providers and the life insurance companies listed above and their reinsurance companies. 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.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may : 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate 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.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to the Company at 120 Office Park Drive, Suite 100 Birmingham, AL 35223. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application or inquiry. I understand that any authorized representative or I will receive a copy of this authorization upon request.

____ ______________________________
Signature of proposed insured/patient or personal representative Date

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Description of personal representative’s authority or relationship to proposed insured/patient