

# Murfee Meadows, Inc.

## Administration and Financial Services

Accordia  
American General  
AVIVA Life Insurance Co  
Banner Life Insurance  
Brighthouse Financial  
Cincinnati Life Insurance  
Global Atlantic  
John Hancock USA/ John Hancock Life  
Lincoln Life and Lincoln Life of NY  
Lincoln National  
LSW (National Life)  
Minnesota Life  
Mutual of Omaha

Nationwide  
One America  
Pacific Life  
Protective Life  
Pruco Life Insurance  
Prudential Insurance Company of America  
Principal Life Group  
Reliastar Life  
Security 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

\_\_\_\_\_  
Description of personal representative's authority or relationship to proposed insured/patient