CONTINENTAL GENERAL INSURANCE COMPANY (CGI)
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Application Authorization Addendum
For Major Medical and Hospital/Surgical Products

I hereby authorize any health care provider, including any physician, practitioner, pharmacy, hospital or medically-related facility, and any insurance company, employer, or, except in AZ and WI, any other organization, institution or person that has my records or knowledge of me or my dependent(s) to disclose to CGI, or its authorized representative, any such records or information. Records or information may include medical records in their entirety, which may contain mental health records (excluding psychotherapy notes), prescription drug records, use of alcohol, or use of controlled or prohibited substances, driving records, financial and employment records. Such records or information will be used by company personnel to determine eligibility for insurance and/or benefits. CGI may disclose such information to its reinsurer(s), precertification firm, individual benefits management firms or any other organization which performs services in connection with the insurance relationship, including, but not limited to, the insurance agent, or as lawfully required. CGI reserves the right to require a medical examination or testing or both. There may be certain circumstances under which the information received may be disclosed to third parties who are not subject to the regulations under federal health privacy law. We contractually require such persons to agree to protect the confidentiality of the information. I understand that I have the right to request access to all personal information collected and, upon written request, I may ask CGI to correct, amend or delete any incorrect personal information. A copy of the Company's "Privacy Notice and Notice of Insurance Information Practices" is available upon request.

This authorization shall be valid for a period of two (2) years from the date signed, one (1) year in Kansas. A photocopy of this authorization shall be as valid as the original. I understand that I, or my authorized representative may receive a copy of this authorization upon request. This authorization may be revoked at any time subject to the rights of anyone who acted in reliance upon the authorization prior to notice of its revocation. This authorization may be revoked upon submission of a written notice to the Home Office. If this authorization was obtained as a condition of obtaining insurance coverage, your right to revoke also is subject to the rights of the Company under any law granting the Company the right to contest a claim under the policy or the policy itself. Revocation or failure to sign the authorization may be a basis for denying an application or eligibility for benefits.

Signature of Applicant:
(Signature of Parent or Legal Guardian required if child is under 18) Date:

Signature of Spouse:
(If applying for coverage) Date:

Signature of Adult Child:
(If applying for coverage) Date:

Signature of Adult Child:
(If applying for coverage) Date:

Signature of Adult Child:
(If applying for coverage) Date:

Signature of Authorized Representative: Relationship: Date:

Authorized Representative's Address:

Authorized Representative's Phone Number:

AEF-0563 (02/26/03)