



# Authorization to Use or Disclose Health Information

*This Authorization complies with HIPAA requirements.*

Full Name of Proposed Policyowner/Certificateholder *(please print)*

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to me or on my behalf or on behalf of my minor dependents to disclose my or my minor dependents' entire medical records and any other protected health information concerning me or my minor dependents to World Insurance Company ("World"). This includes but is not limited to information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize World to use/disclose my or my minor dependents' entire medical records and any other protected health information concerning me or my minor dependents to any of my Providers.

By my signature below, I understand that any agreements I have made to restrict my or my minor dependents' protected health information does not apply to this authorization and I instruct my Providers or World to release and disclose my or my minor dependents' entire medical record without restriction.

This health information is to be used or disclosed under this authorization so that World or my Providers may: 1) underwrite the application for coverage, make 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 World or 6) for general treatment, payment or health care operations.

This authorization shall remain in force for [24 months] following the date of the 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 World at 11808 Grant Street, Omaha, Nebraska 68164. I understand that a revocation is not effective to the extent that any of my Providers or World has relied on this authorization or to the extent that World 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 federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the complete medical records, World may not be able to process my application for insurance. I understand a copy of this authorization will be provided to me.

Signature of Policyowner/Certificateholder

Date

Signature of Spouse (if covered)

Date

*Signature of each Covered Dependent age 18 and over:*

Dependent Signature

Date

Dependent Signature

Date

Dependent Signature

Date

If signed by a legal representative of policyowner, please indicate the legal representative's authority to act on behalf of the policyowner/certificateholder.

Signature of Legal Representative

Authority

Date