Lumico
family of insurance companies

Lumico Life Insurance Company
123 Town Square Pl. #798, Jersey City, NJ 07310
1-800-589-0087
www.lumico.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Claims HIPAA Compliant Authorization for Release of Information to Lumico Life Insurance Company.

This Authorization complies with the HIPAA Privacy Rule.

I understand that the information obtained by use of this Authorization will be used by Lumico Life Insurance Company ("the Company") to determine eligibility for benefits under the insurance policy or policies on:

Insured's Full Name (please print) Policy Number(s)

I hereby authorize any physician or other medical professional, hospital, clinic, healthcare provider, Medical Examiner, Coroner, or other medical-care institution or medical related facility, pharmacy or pharmacy benefit manager, employer, contractor, business associates, insurance or reinsurance company, group policyholder, insurance support organizations, benefit plan administrator, consumer reporting agency, financial institutions, governmental or law enforcement agencies, Social Security Administration, the Veterans Administration, and the Department of Motor Vehicles, life settlement companies, life expectancy companies, family members, friends, neighbors, or associates having information as to diagnosis, treatment, and prognosis, including drug and alcohol abuse information, and any information with respect to Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV), and any information with respect to mental or psychiatric conditions or disorders, autopsy and toxicology reports, and any employment or wage or financial information, information about driving records (MVR), criminal records, and information with respect to other insurance coverage or claims or the insured or family members for which claim is being made, to release to the Company or its representative, any and all such information for a period of 20 years prior to the date of this Authorization including medical records, office notes (excluding psychotherapy notes), test results, personal history information, history and physical, admission records, discharge summaries, consultations, operative reports, and outpatient and ER records for the above named Insured.

I understand that the information released under this Authorization will be used for the purposes of evaluating and administering a claim for benefits, and I understand that the Company may be unable to evaluate my claim if this Authorization is not signed and dated. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required, or as I may further authorize.

This Authorization is valid for the duration of the claim or for a maximum of 24 months from the date shown below. I know that I have a right to request a copy of this Authorization and to revoke this Authorization at any time in writing by sending notice to the Company. The revocation is only effective after it is received by the Company; any use or disclosure prior to the revocation will not be

affected by a revocation; a revocation is not effective to the extent that the Company has a legal right to contest a claim under a policy or to contest the policy itself and its benefits or riders; after the health information is disclosed, federal law might not protect it and the recipient might re-disclose it.

I agree that a photographic copy of this Authorization shall be as valid as the original. I acknowledge receipt of a copy of this Authorization.

Claimant's Full Name (please print) | Relationship to Insured

Claimant's Signature | Date Signed

Address (Number and Street) | City | State | ZIP Code

Claimant Copy

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Claimant's Signature | Date Signed

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Office Copy