Recorded Authorization for Release of Health Information to:

Senior Life Insurance Company
P.O. Box 2447
Thomasville, GA 31799-2447

I authorize any health care provider, plan, or clearinghouse, insurance company, pharmacy, pharmacy benefit manager, Medical Information Bureau, or Consumer Reporting Agency to disclose to Senior Life all medical records, including information on medical consultations, treatments, surgeries, or hospital confinements for physical and mental conditions, use of drugs, alcohol, or tobacco, prescription drugs, communicable diseases such as HIV or AIDS, excluding psychotherapy notes.

This information will be used by Senior Life to determine your eligibility for insurance, administer your coverage, and process your claims. Other entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. This authorization will expire in 24 months. A copy of this authorization shall be as valid as the original. You are entitled to receive a copy of this authorization. You may revoke this authorization at any time by sending written notice to Senior Life, but any action taken in reliance on this authorization cannot be reversed. You are not required to sign this authorization, but without it, Senior Life cannot process your application. By signing this application I hereby sign and agree to the HIPPA authorization.

Signature of Proposed Insured	Time	Date