

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION & POLICY INFORMATION

The undersigned hereby authorizes any physician, medical personnel, clinic, hospital, medical center, medical bureau, insurance company, and/or any other health care provider holding protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("Protected Health Information") regarding the person(s) identified below as the Insured, to disclose and/or release all Protected Health Information concerning or related to the medical or health condition of the Insured to each of the following (each, a "Recipient"): (i) the below-named designee (the "Designee"), if any, (ii) to Wm. Page & Associates, Inc., d/b/a The Lifeline Program® (the "Company"), and (iii) to the employees, agents, representatives, successors, assigns, and designees of the Company, for the purpose of obtaining an estimate of, or reviewing, the life expectancy, personal status, and/or health status of the Insured. The undersigned further authorizes any insurance company providing life insurance coverage on the life of the Insured to furnish to a Recipient any and all information and/or documents which the Recipient may request in connection with such life insurance coverage, without limitation.

This authorization shall remain valid for the longer of (a) twenty-four (24) months following the date below or (b) the maximum period of time permitted under federal law and the laws of the U.S. state of which, as of the date hereof, the Insured is a resident.

This authorization is voluntary, and the Insured (or, an authorized personal representative if acting on behalf of the Insured) can refuse to sign this authorization. Treatment, payment, enrollment, or eligibility for health benefits may not be conditioned by the health care providers of the Insured on the signing of an authorization, except as otherwise permitted by law. Any information, including but not limited to Protected Health Information, used or disclosed pursuant to this authorization may be subject to re-disclosure by a Recipient and may no longer be protected by federal and/or state privacy and confidentiality rules.

The signatory below providing this authorization may revoke this authorization in writing if revocation is delivered to the Designee and to the Company via first-class certified postage-prepaid mail, return receipt requested. Any revocation of this authorization shall not apply to the extent that any Recipient previously has relied upon this authorization.

This form may be signed in any number of counterparts, all of which together shall constitute one and the same original form. A photocopy or facsimile of this signed authorization is a valid representation of the original and shall be treated, and may be relied upon as, an original.

By signing below, the undersigned acknowledges that this authorization is written in plain English and will retain a copy of this signed authorization.

Designee _____
PRINT OR TYPE NAME OF PERSON OR ENTITY

Insured Information _____ _____ / /
PRINT OR TYPE NAME SIGNATURE DATE

Insured Date of Birth & Social Security Number _____ / / _____ - -

Witness _____ _____ / /
PRINT OR TYPE NAME SIGNATURE DATE

Policyowner Information _____ _____ / /
(only required if the Insured is not the Policyowner) PRINT OR TYPE NAME SIGNATURE DATE

Policyowner Date of Birth & Social Security Number _____ / / _____ - -
(only required if the Insured is not the Policyowner)

Witness _____ _____ / /
(only required if the Insured is not the Policyowner) PRINT OR TYPE NAME SIGNATURE DATE

If this form is signed by an Authorized Personal Representative of the Insured, please describe authority to act on behalf of the Insured in the space provided below (in printed or typed text).

