# HIPAA AUTHORIZATION

American Republic Insurance Company
601 6th Avenue, Des Moines, Iowa 50309

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to American Republic Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: American Republic Insurance Company, P.O. Box 9371, Des Moines, Iowa 50360-9371.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. (180 days for confidential HIV-related information).
- I have the right to ask for and obtain a copy of any consumer report made about me to the Company.

I agree that a copy of this Authorization is as valid as the original.

Date
MM / DD / YYYY

Your Name (Please print)

Your Signature
X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)
X

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)
X

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)
X

Your Child(ren)'s Name(s) if younger than 18 (Please Print)

1. 3.

2. 4.

**A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:**

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal Representative
X

| Person(s) to be Insured (Please print) | My relationship to applicant(s) (Please print) | Person(s) to be Insured (Please print) | My relationship to applicant(s) (Please print) |
|---|---|---|---|
| 1. | 1. | 3. | 3. |
| 2. | 2. | 4. | 4. |

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# AUTHORIZATION TO DISCLOSE INFORMATION

I authorize American Republic Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention. I understand that I do not have to authorize this disclosure to MIB. Issuance of coverage will not be conditioned on me signing this authorization. ☐ Yes ☐ No

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: American Republic Insurance Company, P.O. Box 9371, Des Moines, Iowa 50360-9371.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Date
MM / DD / YYYY

Your Name (Please print)

Your Signature
X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)
X

**A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:**

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal Representative
X

| Person(s) to be Insured (Please print) | My relationship to applicant(s) (Please print) | Person(s) to be Insured (Please print) | My relationship to applicant(s) (Please print) |
|---|---|---|---|
| 1. | 1. | 3. | 3. |
| 2. | 2. | 4. | 4. |

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