DEPENDENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Employer/Group Name________________________________ Group Number (if available)______________________________

Employee Name____

Name of Dependent____

I hereby authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc. ("MIB"), or other organization, institution or person (including any consumer reporting agency) that has any records or knowledge of me or my past or present health, to release any information regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the purpose of evaluating my eligibility for insurance coverage. Information subject to this Authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; income; and my use of alcohol, drugs, and tobacco. This information will be used only to determine eligibility for insurance. This authorization does not authorize the release of genetic screening or testing results.

I authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my personal health information to MIB, Inc. All sources except MIB, Inc. may disclose this information to any insurance support organization authorized by USAble Life to collect and transmit it.

This authorization shall remain valid for a period of two years beginning the later of the date of my signature below or the issue date of the coverage. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to me or my representative upon request to USAble Life.

I understand that this authorization may be revoked at any time. Such revocation must be in writing, and will not be effective until USAble Life and the provider of the information receive it. My revocation will not be effective with respect to disclosures made by a covered entity in reliance on this authorization before it was revoked. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

If an investigative consumer report is made, I can choose to be interviewed and to receive a copy of the report upon request.

I understand that any insurance will not take effect unless and until USAble Life approves this enrollment request.

Dependent Signature____Date________________________________

Printed Name_______________________________ Date of Birth____/____/____ Social Security No.______-_____-________

You can obtain this form in a fillable .pdf format on USAble Life's Document Center at https://yourdocumentcenter.com.

Please return the completed Authorization to us:

By Mail: USAble Life
ATTN: Membership & Billing
P.O. Box 1650
Little Rock, AR 72203

By Facsimile: (501) 235-8419

By Email: Maintenance@usablelife.com