AMERICAN FAMILY LIFE INSURANCE COMPANY
6000 AMERICAN PKWY
MADISON, WISCONSIN 53783-0001
1-800-MYAMFAM (1-800-692-6326)

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

FOR LIFE INSURANCE PURPOSES ONLY

PATIENT'S NAME (FIRST)	(MI)	(LAST)	(SUFFIX)

ANY PREVIOUS NAME(S)	BIRTH DATE

STREET ADDRESS

CITY/TOWN	STATE	ZIP

I hereby authorize the use or disclosure of ALL individually identifiable health information (health information), including but not limited to paper and/or electronic format **from** any physician or health care facility (including but not limited to any specific physicians or health care facilities listed below), consumer reporting agency, pharmacy benefit manager, pharmacy related services organization, employer, insurance or reinsurance company, insurance agent, governmental or other organization, the MIB, Inc. (MIB), a family member or other person **to** American Family Life Insurance Company (the Company), 6000 American Pkwy, Madison, WI 53783, or any person or group acting on behalf of the Company.

To facilitate the collection of such information, I further authorize the Company to insert the names and addresses of physicians or health care facilities in the space below. I understand that the names and addresses of such providers may be inserted by the Company after I have signed this form, and agree that this authorization is intended to extend to all such providers. I understand that this process is being used as a convenience to me to speed the processing of my application for life insurance.

To be completed by American Family Life Insurance Company

PHYSICIAN/HEALTH CARE FACILITY'S NAME

STREET ADDRESS

CITY/TOWN	STATE	ZIP

I understand that the aforementioned parties requesting access to my (electronic or paper) health information are acting as a patient authorized representative and will attempt to access my health information in the most efficient manner possible, including electronic interchange through a Health Information Exchange or directly through my physician or health care facility's electronic health record system.

I understand the disclosure of all health information includes facts regarding my physical or mental health or that of my minor child(ren) and diagnosis or medical history, prescription history, psychiatric history or treatment, results of genetic tests (unless prohibited by law), treatment or prognosis of any physical or mental condition and drug or alcohol abuse history or treatment and/or any nonmedical information. This disclosure will include information related to Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS). I further understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization, and that information, once disclosed may no longer be protected by federal rules governing privacy and confidentiality.

I understand the Company requires this information:

- for underwriting purposes to determine eligibility, risk rating and policy issuance determinations;
- to obtain reinsurance;
- to administer claims and determine or fulfill responsibility for coverage and provision of benefits; or
- to administer coverage.

I understand that such information may be disclosed by the Company to affiliates, insurance or reinsurance companies, MIB, persons or organizations conducting bona fide actuarial or scientific research studies, audits or evaluations, or to other organizations or persons performing services in connection with this life insurance application or any claim submitted or required by law.

I understand that the (proposed) insured, authorized person or personal representative:

1. is entitled to receive a copy of the completed authorization form;
2. may revoke this authorization at any time by notifying the Company in writing to the address above, and that revocation of the authorization will not have any effect on actions taken:
    a. in reliance upon the authorization prior to any revocation; or
    b. if applicable, during a contestable period.

I further understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining the patient's, authorized person's or personal representative's signature. I may refuse to sign this authorization, but such refusal may affect the (proposed) insured's eligibility for insurance or insurance benefits with the Company.

I agree that a copy of this authorization may be used in place of the original and this authorization will automatically expire 24 months from the date of signature if no prior written revocation is sent to the Company. This time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. For signature purposes, I understand that "authorized person" means the insured, or the parent or legal guardian for proposed insureds who are either legally incompetent or under age 18.

PATIENT/AUTHORIZED PERSON'S SIGNATURE*		DATE
STREET ADDRESS		
CITY/TOWN	STATE	ZIP
RELATIONSHIP TO PATIENT	TELEPHONE #	
TRANSLATOR'S SIGNATURE (IF APPLICABLE)	DATE	

*An entity may not sign as the authorized person