OFFICE COPY

HERMANN SONS LIFE

Health Insurance Portability and Accountability Act

Name of proposed insured/patient (please print) Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager or other health care provider that has provided services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me with Hermann Sons Life, a life insurance company. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Hermann Sons Life may: 1) underwrite my application for coverage, make eligibility, risk rating and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Hermann Sons Life.

A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Hermann Sons Life at 515 South St. Mary's Street, San Antonio, TX 78205-3430. I understand that my information that is disclosed pursuant to this authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

This authorization, and all authority to disclose information pertaining to me, shall expire 90 days from the date of the signature below, unless earlier revoked by me in writing.

I understand that if I refuse to sign this authorization to release my complete medical record Hermann Sons Life may not be able to process my application. I acknowledge that I have received a copy of this authorization.

I understand and agree that Hermann Sons Life may disclose all or some of the information that it collects about me to MIB, LLC, company reinsurers, and contractors and others who may perform business services for Hermann Sons Life relating to my application or insurance coverage (generally known as "service providers" or "business associates").

Signature of Proposed Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

Witness/Agent Date

CLIENT COPY

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Name of proposed insured/patient (please print) Date of Birth

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