

Policy Numbers:	_____

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and/or Medico™ Life Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico™ Insurance Company and/or Medico™ Life Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico™ Insurance Company and/or Medico™ Life Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico™ Insurance Company and/or Medico™ Life Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that either Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

Printed Name of Applicant/Insured

Signature of Applicant/Insured

Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

Printed Name of Personal Representative

Description of Personal Representative's Authority

Signature of Personal Representative

Date