P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

Authorization for the Use and Disclosure of Information

I hereby authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to use and/or disclose the following information about me as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations**.

Policy/Identification Number: ____

____ ____ /____ /____

Full name of insured whose information is being requested for use/disclosure *Date of Birth*

1. Persons/class of persons authorized to use or make disclosure of the information: **The Company staff with appropriate access clearance to use and disclose the applicable information.**

2. Name and address of persons/class of persons authorized to receive the information: ___________________________

   ____

3. Specific description of information that may be used/disclosed:
   __ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, claim information, etc.)
   __ **Personal Information** (such examples may include, but is not limited to, the following: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, employer, prior insurance information, etc.)
   __ **Bank Information** (such examples may include, but is not limited to, the following: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
   __ **Coverage Information** (such examples may include, but is not limited to, the following: Effective date, paid-to date, premium amounts, mode of payment, names and policy/certificate provisions specific to covered member(s), medical waiver(s)/rating(s) on coverage, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
   __ **Other**, please specify: ____

4. The information will be used/disclosed for the following purposes (*all* purposes must be listed and described):
   __ **Benefit/Payment Purposes** (examples include, but are not limited to, the following: for processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs)
   __ **Coverage Maintenance** (examples include, but are not limited to, the following: perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment)

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Medico Insurance Company administers for Ability Insurance Company
Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company

__ **Coverage Changes** (examples include, but are not limited to, the following: to add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes)

__ **Other**, please specify: ____

5. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   a. the Company or another third party has taken action in reliance on this authorization; or
   b. this authorization is obtained as a condition for obtaining insurance coverage, as other laws may provide the Company with the right to contest a claim under the policy/certificate or the policy/certificate itself.

   I understand to revoke my authorization I should send my written revocation request to:

Medico
Customer Service Center
P.O. Box 10386
Des Moines, Iowa 50306-0386

6. This authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

Fill in the information in the following paragraph ONLY if you are completing this authorization as a personal representative of the policy/certificate holder and sign and date the completed form.

I, ____, hereby certify and attest that I am the duly authorized personal representative of ____, that my relationship to the policy/certificate holder is ____, and that I have the lawful authority to enter into this authorization on behalf of the policy/certificate holder. I have read the provisions set forth in this authorization, and agree that the Company and its affiliates may use and/or disclose the aforementioned information for the purposes set forth herein.

Please enclose a copy of the legal document that shows you are a personal representative for the policy/certificate holder when you return this form.

____	____________________
Signature of Individual or Personal Representative	*Date*
____	____________________
Printed Name of Individual or Personal Representative	*Relationship of Personal Representative or Authority to Act for the Individual*

You will be provided a copy of this signed authorization.