



Review & Sign Insured's Statement and HIPAA Compliant Authorization to Release Medical Information

I hereby apply to United Security Life & Health Insurance Company for insurance. I represent the statements I have made herein are complete and true. I understand the following: (a) if any material information on this application is incorrect, this coverage may be voided; and, (b) if this application is declined and a certificate is not issued, United Security Life & Health Insurance Company's only obligation will be to return any premium paid; and, (c) that United Security Life & Health Insurance Company will pay benefits for a loss due to a pre-existing condition provided the pre-existing condition was fully disclosed in the application and this coverage has not been excluded or limited by name or specific description; and (d) there is no insurance in force until a certificate indicating the effective date is received from United Security Life & Health Insurance Company and the initial premium, including the applicable fee, is paid in full. By this form (or copy), I authorize any medical practitioner, physician, pharmacist, pharmacy-related facility, hospital, clinic, healthcare professional, medically-related facility, records custodian, insurance company, or the Medical Information Bureau, that has any records of me or any members of my family named in this application, of our health, to give United Security Life & Health Company, its reinsurers, affiliates, or business associates, any such information which shall include but not be limited to, Alcohol or Drug abuse treatment, mental health diagnosis and treatment, Pharmacy prescriptions, HIV testing and treatment, Sexually Transmitted Disease (STD) testing and treatment, Genetic testing, Sickle Cell testing and treatment, lab data, and diagnostic testing.

I understand the information obtained by use of this authorization will be used by the insurance company to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal service in connection with my application, claim, or as may otherwise lawfully require or as I may further authorize. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. This authorization shall be valid for two and one half years from the date shown below. For residents of Arizona, this authorization is valid for 180 days for any HIV-related information. For residents of Nebraska, this authorization is valid for twenty-four months. I acknowledge receipt of the important notice regarding a consumer report disclosure of information to the Medical Information Bureau. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to United Security Life & Health Insurance Company, P.O. Box 388342, Bedford Park, Illinois 60638, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that United Security Life & Health Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. A photographic copy of this authorization and acknowledgement shall be as valid as the original.

Upon request, I or my authorized representative, is entitled to receive a copy of this authorization form. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit of knowingly present false information in an Application for Insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Disclaimer – If premiums are paid from your employer's account, it is understood that: (1.) United Security Life & Health Insurance Company assumes no responsibility for compliance with the Employee Retirement Income Security Act of 1974 (ERISA) and amendments thereto, nor does it maintain that the policy is designed or marketed to comply with the requirements contained therein. The Company is not acting as a sponsor as defined in ERISA. Any compliance under this Act that is applicable to the sponsor will be fulfilled by the employer, as his own legal counsel may determine. United Security Life & Health Insurance Company assumes no responsibility for collection of premiums and/or failure of your employer to remit them on a timely basis. (2.) By signing below, I am also certifying that I am not eligible to receive Medicare benefits.

Primary Insured Signature	Spouse Signature (if to be covered)	Date
Dependent Signature (if over age 18)	Dependent Signature (if over age 18)	Date
Agent Signature	Agent Number	Agent Email Address



Select Payment Type: Annual Semi-Annual Quarterly Monthly Bank Draft Credit Card Direct Bill

Billing Fees: Annual - \$0.00 • Semi-Annual - \$3.00 • Quarterly - \$2.00 • Monthly - \$1.00 • PAC/Credit Card - \$0.00 • List (monthly) - \$5.00

If paying by credit card, please complete the information below:

Card Type: Visa MasterCard Discover **Card Number:** _____ **Exp. Date:** ____/____/____

If paying by monthly bank draft, please complete the information below:

As a convenience to me, I hereby request and authorize you to pay and charge my account (check or electronic debit) drawn on my account by and payable to United Security Life & Health Insurance Company, provided there are sufficient funds in said account to pay the same on presentation. I agree that your rights with respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance. This authorization is to remain in effect until revoked by me in writing, and until you actually receive such notice.

Bank Name	Bank Address
Printed Name	Signature
	Date