

LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604

Phone (800) 366-8354

AUTHORIZATION FORM FOR DISCLOSURES OF AN INSURED'S PROTECTED HEALTH INFORMATION TO DESIGNATED PERSONAL REPRESENTATIVE(S)

I hereby authorize the use or disclosure of protected health information about me by Loyal American Life Insurance Company (hereinafter "the Company") as described below.

The purpose of this authorization is to allow the individual(s) listed below to act as my personal representative(s) in the disclosure, use or request of my protected health information. The Company may release my protected health information which is described below to the following person(s):

Name	Address	Relationship	Date of Birth	Social Security #

Describe fully the protected health information that is NOT allowed to be disclosed to the above named personal representative(s).

I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of the Company, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Officer at P.O. Box 1604, Duncan, Oklahoma, 73534-1604.

This authorization will expire upon the earliest of the following:

This date: _____; or twenty-four (24) months from the date the authorization is signed.

I understand that I am not required to sign this authorization form and that the Company will not condition the provision of payment to me on the signing of this authorization. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I understand that I or my personal representative is entitled to receive a copy of this authorization upon request.

Insured Name

Personal Representative (if applicable)

Signature of Insured or Representative

Relationship of Representative to Insured

Date of Signature

Insured's Policy Number