USFL
PO Box 3016
Monroe, WI 53566-3016
Phone: 800-959-3894
Fax: (803)-233-3725

U.S. FINANCIAL LIFE Insurance Co.

HIPAA FORM

Proposed Insured's Name _____Date of Birth_____

AUTHORIZATION TO RELEASE INFORMATION PROTECTED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

TO OBTAIN HEALTH INFORMATION In this authorization, "I" "We" "Our" "Me" and "Us "means the Proposed Insured/Patient or Authorized Representative. I (We) authorize any physician, hospital, clinic, medical practitioner, medical testing laboratory, pharmacy, pharmacy benefit manager, medically related facility or other health care provide, health plan or insurance company (including the Company above, with respect to other coverages) and the Medical Information Bureau to disclose to the Company and its authorized representatives (collectively hereinafter the "Company") any and all information, including medical reports, pharmaceutical records or prescription history, whether fact or opinion, they may have about any diagnosis, treatment, medication or drug history, and prognosis regarding my past, present or future physical or mental condition.

RE-DISCLOSURE OF HEALTH INFORMATION I (We) understand that any disclosure of information to the Company for the purpose of determining my (our) eligibility for coverage carries with it the potential for re-disclosure, meaning the information may no longer be protected by HIPAA. However, please note that such information may be protected by other state and federal privacy laws such as the Gramm-Leach-Bliley Act.

PURPOSE OF AUTHORIZATIONS I understand the following parties may need to collect information on me in regard to the proposed coverage: The Company and its reinsurers; any insurance support organization; any customer reporting agency; and all persons authorized to represent these organizations for this purpose. I (We) understand that the information obtained will be used by the Company to determine my (our) eligibility for life insurance coverage and any associated risk rating classification, and to obtain reinsurance. If a policy is issued to me (us), this information may also be used in the future to administer my (our) policy and process claims made under the policy. In addition, information may be disclosed to the Medical Information Bureau (MIB) who, upon request, may disclose such information about me (us) in its file to another member company with whom I (we) apply for life or health insurance or to whom a claim for benefits may be submitted; when requested by a government agency; in connection with a legal or arbitration proceeding; or for other purposes as required or permitted by applicable law. COVERAGE CONDITIONS I (We) understand that the Company is conditioning the issuance of coverage on the provision of this authorization, and that, while I (we) may refuse to sign this authorization, my (our) refusal to do so could result in coverage not being issued.

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ADDITIONAL AUTHORIZATIONS You have advised me (us) that the Company may request additional authorizations in order to obtain the information the Company needs to complete its review of my (our) application and, if the policy is issued, in connection with any claim asserted under the policy. I (we) understand that I (we) am not obligated to provide these additional authorizations but that, if I (we) choose not to provide them, this application and any claim made under the policy, if issued, may be rejected. DURATION Unless otherwise revoked, I (we) agree that this authorization will expire on the earlier of the date that the Company declines my application for coverage or, if a policy is issued, 24 months from the date of my application. I (We) understand that I (we) may revoke my (our) authorization at any time. No termination or revocation shall affect (1) any action that the Company has taken in reliance on this authorization or (2) any right granted the Company by law to contest a claim under the policy or the policy items. If I (we) choose to revoke any authorization, the application and any claim made under the policy, if issued, may be rejected. My revocation must be submitted in writing to: U.S. Financial PO Box 3016 Monroe, WI 53566-3016 Attention: Privacy Official. COPY OF AUTHORIZATIONS I (We) have a right to ask for and receive true copies of this Authorization Form and all other authorizations signed by me (us). I (We) agree that reproduced copies will be as valid as the original.

Signature of Proposed Insured/Patient or Authorized Representative

_____

Print Name of Proposed Insured/Patient or Authorized Representative

_____

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

_____

Date at City, State _____on _____(mm/dd/yyyy)