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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule.

NAME OF PRIMARY PROPOSED INSURED/PATIENT	INSURED'S DATE OF BIRTH
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For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, medical care facility, pharmacy, pharmacy benefit manager, the Veteran's Administration, or other health care provider, and any insurance company, insurance support organization, insurance laboratories, my employer, consumer reporting agency, or state department of motor vehicles to disclose information about me, including but not limited to, my entire medical record or any other protected health or consumer information to Christian Fidelity Insurance Company ("Christian Fidelity"), its reinsurers, and those who perform services for Christian Fidelity related to an insurance application or a claim. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol or drugs. I agree that a copy of this authorization, or my recorded voice or electronic authorization, is as valid as the original and I can obtain a copy on request. This authorization is valid for 36 months (or a shorter time-period if required by applicable state law) from the date of this application (180 days for HIV-related information), regardless of my condition and whether living or deceased.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under the authorization at my request, as permitted by § 164.508 of the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act ("HIPAA Privacy Rule").

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Christian Fidelity addressed, **Attention: Policyholder Service Department, 2721 North Central Avenue, Phoenix, AZ 85004**. 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 Christian Fidelity has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, Christian Fidelity will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record Christian Fidelity may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.



 Signature of Insured _____
 Date

If signed by the Insured's Personal Representative, describe the authority to sign on behalf of the Insured:

Power of Attorney (please attach) Other (please describe): _____

Proposed Insured Policy or Contract Number (if known): _____