

**Authorization for Release of Health-Related Information
to Farmers New World Life Insurance Company
This Authorization complies with the HIPAA Privacy Rule**



FARMERS
LIFE INSURANCE

Name of Proposed Insured (please print)

____/____/____
Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf (“Providers”) to disclose my entire medical record and any other health or billing information concerning me (“Health Information”) to Farmers New World Life Insurance Company (FNWL) and its agents, employees, representatives, and reinsurers.

Health Information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Health Information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I am authorizing the Providers to disclose Health Information for the purpose of processing my application for life insurance and, if coverage has been issued, administering the life insurance policy.

By my signature below, I acknowledge that any agreements that I have made to restrict my Health Information do not apply to limit disclosures under this Authorization and I instruct any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This Authorization shall remain in force for 24 months following the date of my signature below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, with respect to any one of the Providers by directly contacting the respective Provider and sending a written request for revocation directly to such Provider. I understand that a revocation is not effective to the extent that any of the Providers has already disclosed information in reliance on this Authorization. I understand that any Health Information that is disclosed pursuant to this Authorization may be re-disclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the Providers may not refuse to provide treatment, payment for health care services, or enrollment or eligibility for benefits if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Health Information, FNWL may not be able to process my application or, if coverage has been issued, may not be able to make any evaluation or process a claim for benefit payments.

I understand that I am entitled to receive a signed copy of this Authorization.

Signature of Proposed Insured, or Authorized Representative or Parent, if required

Date

Description of Representative’s Authority to act for the Proposed Insured or Relationship to Proposed Insured

Farmers New World Life Insurance Company
3003 77th Avenue S.E., Mercer Island, WA 98040-2890 / (206) 232-8400
Columbus Life Office: PO Box 182325, Columbus, OH 43218-2325 / (614) 764-9975
Variable Policy Service Office: PO Box 724208, Atlanta, GA 31139 / 1-877-376-8008

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