

## Authorization To Disclose Personal Information

1. I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

Applicant Name: \_\_\_\_\_  
(Last) (First) (Middle)

2. Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.
3. You may release information to:

Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company  
Attn: Group Insurance Underwriting Individual Selection  
P.O. Box 2476  
Omaha, NE 68103-2476  
or  
Fax 402-351-2537

4. I understand that the personal information that is disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my application and that if I refuse to sign this authorization my application may not be approved.
5. I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the personal information may be redisclosed without the protection of the federal privacy regulations.
6. This authorization will expire 24 months after the date signed.
7. I understand that I may revoke this authorization at any time by providing a written request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company at the address above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.
8. I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

### RETAIN A SIGNED COPY FOR YOUR RECORDS

Name(s) used for records (if different than the name below): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

If Applicable: I am the legal representative of the applicant and I am authorized to grant permission on behalf of the applicant.

Printed Name of Legal Representative: \_\_\_\_\_

Signature of Legal Representative: \_\_\_\_\_

Type of Legal Representative: \_\_\_\_\_

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS