The Savings Bank Mutual Life Insurance Company of Massachusetts
One Linscott Road, Woburn MA 01801
Telephone (800) 694-7254 ~ www.sbli.com

Name of Insured (print) _____ Date of Birth _____ Social Security Number _____

AUTHORIZATION TO COLLECT AND DISCLOSE RECORDS

This Authorization complies with the Health Insurance Portability and Accountability Act ("HIPAA")

I hereby authorize all the entities listed below that have provided payments, treatments, or services to me, or on my behalf, to disclose to The Savings Bank Mutual Life Insurance Company of Massachusetts (the "Company") and its Producers, employees and representatives, including insurance support organizations, the following information: any and all information relating to my health and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments or surgeries, hospital confinements for physical and mental conditions, use of alcohol, drugs, and tobacco; drug prescriptions and communicable diseases, including Human Immunodeficiency Virus (HIV) and AIDS, and any other personal information about me.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician, medical practitioner, or health care professional;
- any hospital, laboratory, pharmacy, pharmacy benefit manager, clinic or other health care facility or provider;
- any insurance company or reinsurance company;
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- MIB Inc. (MIB)

This information may be disclosed pursuant to this authorization so that the Company can use it to:

- determine my eligibility for insurance;
- underwrite my application and make risk rating, policy issuance and enrollment determinations;
- determine my eligibility for benefits under the Conditional Receipt Agreement;
- obtain reinsurance;
- if a policy is issued or reinstated, administer coverage, administer claims, and determine or fulfill responsibility for coverage and provision of benefits; and
- conduct other legally permissible activities that relate to any insurance coverage I have or have applied for with the Company.

- 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 any physician, medical practitioner, hospital, clinic, or other health care provider to release and disclose my entire medical record without restriction. I understand that my health care providers cannot refuse to provide treatment or payment for health care services if I refuse to sign this Authorization.
- I further authorize the Company to release any information obtained by this authorization to MIB Inc., other insurers in which I have policies or to which I may apply or to which a claim for benefits may be submitted, to reinsurers, and to other persons or organizations performing legal or business services in connection with my application or claim. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.
- I authorize the Company to release to me, or to my physician, results that I may request of any medical or laboratory tests taken in connection with this application.
- I also understand that failure to sign this Authorization statement, or the subsequent revocation of this Authorization by me, may impair the ability of the Company to process my application or evaluate claims; and may be a basis for denying an application or claim for benefits.
- By signing below I agree to the terms of this Authorization and acknowledge that I have read and understand it.

I may revoke this Authorization in writing at any time, except to the extent that action has been taken in reliance of this Authorization or to the extent the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself, by sending a written request to: The Savings Bank Mutual Life Insurance Company, P.O. Box 4048, Woburn, MA 01888.

This authorization shall remain in force for 24 months following the date of my signature below or for the duration of any claim for benefits. A copy of this authorization is as valid as the original. I acknowledge that I have received a copy of this authorization.

FOR MAINE and VERMONT APPLICANTS, this Authorization excludes the release of any information relating to previously administered test for HIV antibodies, T-Cell counts, AIDS or ARC, by the applicants family/regular/attending medical doctor/physician/practitioner or care giver or any other person or entity which may possess this information. This exclusion extends to any medical doctor, doctor of osteopathy, physician health care professional, hospital, clinic, medical facility, the Veterans Administration, employer, consumer, reporting agencies, other insurance companies, or anyone else with respect to previous test results. The applicant is not authorizing the Company to forward the results from any new test, requested of the applicant by the Company to an outside, non-affiliated company, nor to any entity not under specific contract with the Company to perform underwriting services.

Date: _____ **Signature of Insured*: X**_____

*If the insured is under the age of 18,
signature of ☐ Parent ☐ Guardian ☐ Other: **X** _____