BOSTON MUTUAL LIFE INSURANCE COMPANY

120 ROYALL STREET · CANTON, MASSACHUSETTS 02021 · 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY

(This authorization complies with the HIPAA Privacy Rule)

Name of *(Proposed)* Insured/Patient *(please print)* — Date of Birth ___/___/___

Name of Second *(Proposed)* Insured/Patient *(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 ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, **to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers.**
This also includes information on the diagnosis and treatment of sexually transmitted disease, mental illness and the use of alcohol, drugs, and tobacco, **but excludes psychotherapy notes. This authorization also excludes disclosure of the results of a test for HIV if the applicant has tested HIV positive for the presence of the human immunodeficiency antigen or the presence of an antibody to the human immunodeficiency virus or who has Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC) or HIV related diseases. Such test results shall not be discovered or published.**

By my signature below, **I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization,** and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) underwrite an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and 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, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself.

We do not disclose information about our customers or former customers to anyone except as permitted or required by law. We may disclose your health information with third parties, without your authorization, as permitted by law. Such information is used to: process or service your insurance transactions with us, perform underwriting, administrative, account maintenance and claims functions, provide customer service or reinsurance coverage and protect against fraud. We may also share your information with a third party to comply with federal, state or local laws, subpoenas or summonses or as otherwise permitted or required by law. Third parties receiving information from us are required to keep it confidential and to comply with all applicable federal and state privacy laws. However, in the course of third parties performing their function your information mav be further disclosed. **I understand that any information that is disclosed pursuant to this authorization may be redisclosed 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 or payment for health care services if I refuse to sign this authorization. **I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments.** I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

Signature of Proposed Insured/Claimant/Patient or Personal Representative — Date

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

Signature of Second Proposed Insured/Claimant/Patient or Personal Representative — Date

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

• DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE •

I, the undersigned, designate _____, the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

Signature of Insured — Date