Lumico
insurance made clear

AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health information exchange, health plan, health insurance plan, health care provider or health care facility, health care professional, clinic, laboratory, medical facility, governmental agency, any insurance company or any other entity that has any diagnosis, prescription or other medical information about me, to disclose my entire medical record and any other protected health information including, the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, alcohol, drugs, and tobacco to Lumico Life Insurance Company or its reinsurers, employees, or representatives ("Lumico"). This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

Lumico and its affiliates may use and disclose information received under these authorizations where required to underwrite your application or if not required, for insurance related operations, to obtain reinsurance and for any purposes described in this consent. Lumico may use and analyze this information for any purposes permitted by law, including general underwriting and insurance purposes, improving products and services, enhancing account administration, internal risk controls, fraud detection, product research and development, and marketing.

These authorizations shall be valid for 30 months from this date, or the time limit permitted by law in the state where the policy is issued, and you may revoke it at any time by sending written notice to Lumico at P.O. Box 10875, Clearwater, FL 33757-8875. Lumico may use your information for an unlimited period for general underwriting and insurance purposes and to improve the products and services.

By signing, I acknowledge that I have read or been read and agree to the authorizations above, and that I have read or been read and agree to this Authorization for Release of Personal and Medical Information.

Name of Proposed Insured	**Date of Birth (mm/dd/yyyy)**

Signature	**Date**