## DEPENDENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Employer/Group	p Name	Group Number (if a	available)
Employee Nam	ne		
Name of Deper	ndent		
hereby authorize any hospital, physician, medical practitioner, clinic, pharmacy, pharmacy benefits manager, medically related facility, insurance company, DMV, MIB, Inc. ("MIB"), or other organization, institution or person (including any consumer reporting agency) that has any records or knowledge of me or my past or present health, to release any nformation regarding me or my past or present health to USAble Life, its reinsurers and legal representatives for the ourpose of evaluating my eligibility for insurance coverage. Information subject to this Authorization includes facts about my physical and mental health, advice or treatment; prescriptions; hazardous activities, driving record; age; occupation; ncome; and my use of alcohol, drugs, and tobacco. This information will be used only to determine eligibility for nsurance. This authorization does not authorize the release of genetic screening or testing results.			
l authorize USAble Life, its reinsurers, and its legal representatives to make a brief report of my personal health information to MIB, Inc. All sources except MIB, Inc. may disclose this information to any insurance support organization authorized by USAble Life to collect and transmit it.			
issue date of th		ation will be as valid as	r of the date of my signature below or the the original. A copy of the authorization is
effective until U to disclosures r		nation receive it. My rev nis authorization before	ocation will not be effective with respect
lf an investigati <sup>,</sup> request.	ive consumer report is made, I can choos	e to be interviewed and	I to receive a copy of the report upon
l understand th	nat any insurance will not take effect unles	ss and until USAble Life	approves this enrollment request.
Dependent Signature		Da	ate
Printed Name_	Date	e of Birth/	Social Security No
You can obtain	this form in a fillable .pdf format on USAk	ole Life's Document Cer	nter at https://yourdocumentcenter.com.
Please return t By Mail:	the completed Authorization to us: USAble Life ATTN: Membership & Billing P.O. Box 1650 Little Rock, AR 72203		
By Facsimile:	(501) 235-8419		



By Email:

Maintenance@usablelife.com