AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I authorize any physician, pharmacy benefit manager, retail pharmacy, clearing house, health plan or insurance company to disclose prescription drug information about me within their possession to Milliman IntelliScript on behalf of LifeMap Assurance Company ("LifeMap"). The purpose of this disclosure is for Milliman to provide the information to LifeMap to evaluate my application for Life, Disability, and/or Critical Illness insurance products.

I understand that this prescription drug information may contain sensitive data, including data related to the treatment of sexually transmitted diseases, HIV/AIDS, mental health and reproduction or contraception (including prenatal care and abortion). I specifically authorize the disclosure of prescription drug information that is related to alcohol or substance abuse and I understand that my alcohol and substance abuse records are protected under Federal law (42 CFR Part 2) and cannot be disclosed without my written consent unless otherwise provided for in 42 CFR Part 2. I also understand that I may cancel this approval at any time, as described below.

I understand and acknowledge the following:

- I may cancel this authorization at any time by sending written notice to LifeMap Assurance Company, Attn: Individual Underwriting, PO Box 1271 M/S E8L, Portland, OR 97207. Cancellation of this authorization will not affect any actions taken by any entity disclosing information before receiving the cancellation notice.
- Completing this authorization is a condition to be eligible for and enrolled in LifeMap Life, Disability and/or Critical Illness insurance products.
- Once any person(s) or entity(ies) discloses my information to an authorized recipient the information could be subject to redisclosure by the recipient and the privacy protections provided by law may no longer apply. Please see LifeMap's Privacy Notice for information on how LifeMap protects the confidentiality of your personal information.
- None of the authorized person(s) and entity(ies) above nor Milliman are responsible for any action taken by an authorized recipient of my protected health information.

This authorization will expire six (6) months from the date signed below.

Applicant Full Name (please print clearly)	Date of Birth (MM/DD/YYYY)
Group Name	Group Number
Applicant Signature	Date

If you are signing this authorization on behalf of another individual, please complete the following and attach documentation demonstrating your authority to act on behalf of the individuals (e.g., Power of Attorney, Guardianship, Conservatorship, etc.)

Name of Personal Representative	Relationship	Phone
Signature of Personal Representative		Date

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