



Authorization for Release of Health-Related Information
This Authorization is intended to comply with the HIPAA Privacy Rule

Name of Proposed Insured/Insured [please print legibly]	Date of Birth
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I, the named person above, authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to American Continental Insurance Company ("ACI") or to its agents, employees, and representatives. This Authorization includes any information regarding the diagnosis or treatment of the Human Immunodeficiency Virus infection and sexually transmitted diseases. This Authorization also includes any information regarding the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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

This protected health information is to be disclosed under this Authorization so that ACI may: 1) underwrite my 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/or 5) conduct other legally permissible activities that relate to any coverage that I have or have applied for with ACI.

This Authorization shall remain in force for twenty-four (24) months following the date of my signature below and a copy of this Authorization is as valid as the original Authorization itself. I understand and agree that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to ACI to the attention of the Underwriting Department at the above address. I understand and agree that a revocation is not effective to the extent that any of My Providers have relied upon this Authorization, or to the extent that ACI has a legal right to contest a claim under an insurance policy or to contest the policy itself since any such revocation may prevent ACI from completing its review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without Authorization by HIPAA and that no action relating to this Authorization shall be construed to create any restriction whatsoever on the uses of my protected health information that HIPAA allows without my Authorization. I understand and agree 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 My 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 my complete medical record, ACI will not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured/Insured	Date	Description of Personal Representative's Authority, if applicable
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TO AGENT: Have Applicant complete and sign front and back of Home Office Copy (White) to submit with application. Give Applicant the Applicant Copy (Yellow).



REQUEST FOR INFORMATION
This Request is intended to comply with the HIPAA Privacy Rule

 Name of Proposed Insured [Please print legibly]

 Date of Birth

I UNDERSTAND that American Continental Insurance Company ("ACI") has other products, services or special discounts that are available to me through it and its business partners. To inform me of these offers, I AUTHORIZE ACI to use or disclose collected information about me to itself, its affiliated companies, marketing partners, agents and service providers. ACI may use my information to determine if certain offers would interest me. Such collected information may include: demographic information, including name and address; information about my transactions and experiences with ACI; information received from me regarding health information, income, assets, credit history or other financial information.

I UNDERSTAND that I am not required to sign this Request for Information and if I fail to do so, such failure will not affect my ability to obtain coverage or available benefits. I also understand that if I decide not to sign this Request for Information, it may prevent ACI from advising or disclosing to me of other non-health related services or products which may interest me in the future.

I UNDERSTAND that ACI WILL NOT disclose any medical records received by ACI from my physician or health care provider pursuant to this Request for Information. If ACI does disclose such collected information, it may receive compensation by its marketing partners or other third parties that receive such collected information.

I UNDERSTAND that any such collected information disclosed pursuant to this Request for Information may be subject to re-disclosure by the recipient and no longer protected by the privacy rule under the Health Insurance Portability and Accountability Act.

I UNDERSTAND that this authorization shall remain valid for twenty-four (24) months from the date stated below. I may exercise my right at any time to revoke this authorization by providing written notice to ACI.

I UNDERSTAND that a copy of this Authorization shall be as valid as the original.

_____ Signature of Proposed Insured/Insured	_____ Date	_____ Description of Personal Representative's Authority, if applicable
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