COVENTRY FIRST
REDEFINING INSURANCE®

7111 Valley Green Road Fort Washington, PA 19034 877.836.8300 coventry.com

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND OTHER INFORMATION

Please sign and include this authorization to release personal, financial, medical and life insurance policy information.

I hereby authorize each healthcare provider, physician, doctor, medical practitioner, physician practice group, nurse, pharmacy, pharmacy benefit manager, laboratory, health information exchange, healthcare clearinghouse, health insurer or health plan, hospital, clinic, medical facility, medical underwriter, and any other person identified below (each, an "Authorized Discloser"), to provide to Coventry First LLC and its affiliates, and its and their respective officers, employees, agents, representatives, financing sources, successors, and assigns ("Coventry First"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Coventry First the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that information disclosed hereunder will be used by Coventry First in connection with potential transactions relating to life insurance policies and other financial products or services owned by me and/or insuring my life, and otherwise as permitted under applicable law.

I hereby authorize my life insurance company to furnish Coventry First with any and all information, including any applications, correspondence, amendments, endorsements, riders, diligence and support files, regarding any insurance policies owned by me and/or insuring my life.

I have a right to receive a copy of this Authorization. I have the right to revoke this Authorization at any time with respect to any Authorized Discloser by notifying such Authorized Discloser and Coventry First of my revocation in writing. I understand that a revocation is not effective to the extent that Coventry First or the Authorized Discloser has already acted in reliance upon my authorization.

I understand that this Authorization is not a consent or authorization requested by a healthcare provider, healthcare clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I further understand that any information used or disclosed pursuant to this Authorization may be used and redisclosed by Coventry First and may no longer be protected by state or federal law.

I am executing and delivering this Authorization voluntarily as of the date written below. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my signing of this Authorization.

I specifically authorize and request each Authorized Discloser to rely upon an electronically signed, photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain in force and effect for one year from the date of my death, or for such other period as allowed by applicable law, at which time this Authorization shall expire.

Additional Authorized Disclosers: _____

Name of Insured _____ Signature _____ Date _____

Date of Birth _____ SSN _____ Email _____ Phone _____

Street Address _____ City _____ State _____ Zip Code _____

Only complete the section below if the policyowner is someone other than the insured.

Name of Policyowner _____ Signature _____ Date _____

Street Address _____ City _____ State _____ Zip Code _____ SSN _____

This authorization may be executed in as many counterparts as may be required. It shall not be necessary that the signature on behalf of all parties appear on each counterpart and it shall be sufficient that the signature on behalf of each party appear on one or more such counterparts.

Life Insurance Policy Information

Policy 1

Insurance company | Face amount | Policy type | Policy number | Issue date

Policy 2

Insurance company | Face amount | Policy type | Policy number | Issue date

Policy 3

Insurance company | Face amount | Policy type | Policy number | Issue date

Insured Physician Information

List all specialty care physicians, such as cardiologist, radiologist, oncologist, etc., who have treated you in the last five years.

Primary Care Physician

Name of primary care physician | Name of office | Phone number

Address | City | State | Zip

Date of last visit | Condition(s) physician is treating | Approximate number of visits per year

Specialty Care Physician 1

Name of primary care physician | Name of office | Phone number

Address | City | State | Zip

Date of last visit | Condition(s) physician is treating | Approximate number of visits per year

Specialty Care Physician 2

Name of primary care physician | Name of office | Phone number

Address | City | State | Zip

Date of last visit | Condition(s) physician is treating | Approximate number of visits per year

Specialty Care Physician 3

Name of primary care physician | Name of office | Phone number

Address | City | State | Zip

Date of last visit | Condition(s) physician is treating | Approximate number of visits per year