



300 S.W. Adams Street Peoria, IL 61634  
Phone 309.674.8255

HIPAA COMPLIANT  
HEALTH INFORMATION AUTHORIZATION

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, or other medical or medically related facility, Medical Information Bureau, Inc. or insurance company that possess health information including prescription history and medications prescribed about me to furnish all such health information to Illinois Mutual Life Insurance Company, hereinafter called the Company. Health information includes any medical treatment records which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes. Illinois Mutual Life Insurance Company may specify the name of the practitioner or facility below.

The Company may obtain health information about me in order to evaluate my application for insurance or my eligibility for benefits under an existing policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to reinsurers who may be involved with my application for insurance or otherwise permitted or required by law in which case it may not be protected under federal privacy rules. This Authorization is required for the underwriting of an insurance policy and failure to provide a signed Authorization may result in a decline of the coverage applied for.

I acknowledge that I have read this Authorization and I will receive a copy of it. I understand and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Illinois Mutual Life Insurance Company, 300 SW Adams St., Peoria, IL 61634. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Proposed Insured or Parent  
if Proposed Insured under 18

\_\_\_\_\_

Print Name of Proposed Insured

\_\_\_\_\_

Date of Birth

Social Security Number

\_\_\_\_\_

Application Number, if known

Home Office Use Only:

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Practitioner or Facility

NOTE TO MEDICAL PROVIDERS: This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also known as HIPAA.