American Republic Insurance Company
American Republic Corp Insurance Company
Medico Insurance Company
Medico Corp Life Insurance Company
Medico Life and Health Insurance Company

Authorization for the Use and Disclosure of Information

I hereby authorize American Enterprise Group, Inc. (the "Company") to use and/or disclose the following information about me as described below. I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.

1. Your Information

Policy/Certificate Number		
First Name	Last Name	Date of Birth (mm/dd/yyyy)

2. Name and address of persons/class of persons authorized to receive the information:

Person or Company Name	Phone Number
Street Address	City, State, and ZIP Code

3. Specific description of information that may be used/disclosed:

- ☐ **Medical Information** (Examples include: Explanation of benefits, medical records, dates of service, amounts payable, health care provider information, services rendered, claim information, etc.) This will include information relating to communicable diseases, including HIV or AIDS, mental health and alcohol or drug use treatment. This will not authorize the disclosure of psychotherapy notes.
- ☐ **Personal Information** (Examples include: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, prior insurance information, etc.)
- ☐ **Bank Information** (Examples include: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
- ☐ **Coverage Information** (Examples include: Effective date, covered person(s), premium information, policy/certificate provisions, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
- ☐ **Other,** please specify:

4. The information will be used/disclosed for the following purposes (all purposes must be listed and described):

- ☐ **Benefit/Payment Purposes** (Examples include: For processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs, etc.)
- ☐ **Coverage Maintenance** (Examples include: Perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment, etc.)
- ☐ **Coverage Changes** (Examples include: To add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes, etc.)
- ☐ **Life Insurance Cash Value Amounts, Beneficiary Information, or Owner Information**
- ☐ **Other,** please specify:

(Continued on back)

5. By signing this Authorization, I understand and agree that:

- The information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.
- The Company will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- I may request a copy of this signed Authorization by sending a request to the Company at the address provided below.
- I may revoke this Authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
    a. the Company or another third party has taken action in reliance on this Authorization; or
    b. this Authorization is obtained as a condition for obtaining insurance coverage, other law may provide the Company with the right to contest a claim under the policy/certificate or the policy/certificate itself.
- This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date it was signed.

You may mail written correspondence to: American Enterprise Group, Inc; Attn: Customer Service; P.O. Box 1; Des Moines, Iowa 50306-0001.

6. If you are completing this Authorization as a personal representative of the policy/certificate holder, please complete this section.

If you have legal documentation that shows you are a personal representative for the policy/certificate holder, please enclose a copy when you return this form. I hereby certify and attest that I am authorized to complete this Authorization due to my relationship to the policy/certificate holder as a:

- ☐ Parent
- ☐ Legal Guardian
- ☐ Power of Attorney
- ☐ Personal Representative
- ☐ Other, please specify: _____

_____

I agree that the Company may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____

Signature of Individual or Personal Representative *Date (MM/DD/YYYY)*

_____

Printed Name of Individual or Personal Representative

* The Company includes, but is not limited to, American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company. American Republic Insurance Company administers for American Family Mutual Insurance Company, S.I., American Family Insurance Company, Continental General Insurance Company, Central Reserve Life Insurance Company, and Provident American Life Insurance Company. Medico Insurance Company administers for Ability Insurance Company and Knights of Columbus Health and Accident Division. Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company.