wellabe®

Authorization for the Use and Disclosure of Information

By completing and signing this authorization, I, or my legal representative, authorize Wellabe, Inc. (the "Company")* and its affiliates, employees, agents and subcontractors, to receive, use and/or disclose my nonpublic personal information as described below.

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:

- ☐ **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, paid-to date, premium information, policy/certificate provisions, policy/certificate numbers, insured member(s) date of birth(s), etc.)
- ☐ **Other,** please specify:

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

- ☐ **Cash value amounts, beneficiary information, and/or owner information**
- ☐ **Other,** please specify:

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.
- I may request a copy of this signed Authorization by sending a request to the Company.
- I may revoke this Authorization at any time by sending my written revocation to the Company. 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 from the date it was signed.

You may mail correspondence to:

Wellabe, Inc; Attn: Customer Success; P.O. Box 1; Des Moines, IA 50306-0001.

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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

If a legal representative signed this form, describe the relationship: _____

If you are signing this authorization as a legal representative of the insured, you must provide legal documentation authorizing you to act on the insured's behalf (e.g. power of attorney, legal guardianship, personal representative, administrator, executor). By signing this authorization, you certify and attest that you are authorized to complete this due to your relationship to the insured.

* The Company includes, but is not limited to, American Republic Insurance Company, American Republic Corp Insurance Company, Great Western Insurance Company, Medico Insurance Company, and/or Medico Life and Health Insurance Company. Medico Insurance Company administers for Ability Insurance Company. Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company.