National Guardian Life Insurance Company (NGL)
Home Office: Madison, WI
Long Term Care Administrative Office
Post Office Box 4243
Woodland Hills, CA 91365-4243
888.505.2332 • Fax 818.887.4595
www.ngl-essentialltc.com

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION RELATED TO AN ADVERSE UNDERWRITING DECISION

"I", "me", "my" means each Applicant signing this Authorization.

This authorization is at the request of the individual or individuals whose names appear below.

In the event my application for insurance is not approved or if my policy is issued at a rate or with benefits other than as applied for ("Adverse Underwriting Decision"), I authorize National Guardian Life Insurance Company (NGL) to disclose the specific reasons for the Adverse Underwriting Decision to my agent and/or to his or her marketing organization. I understand that NGL will not condition eligibility for coverage, underwriting or risk rating determination, or payment of benefits on any provision of this authorization.

REDISCLOSURE OF INFORMATION

I understand that if the person(s) or organization(s) that receives information provided pursuant to this authorization is not subject to federal privacy regulations, the information may be redisclosed and will no longer be protected by the federal privacy regulations.

REVOCATION OF AUTHORIZATION

As described, I understand that I may revoke this authorization in writing at any time by sending a written revocation to: National Guardian Life Insurance Company (NGL), Long Term Care Administrative Office, ATTN: Privacy Administrator, P.O Box 4243, Woodland Hills, CA 91365-4243. I also understand that any such revocation will not be effective to the extent that action has been taken by NGL in reliance on this authorization or the extent that NGL has a legal right to contest a claim under the policy which I have applied for or to contest the policy itself.

EXPIRATION OF AUTHORIZATION

This authorization will be valid for 24 months from the date of my signature below.

A copy of this authorization is as valid as the original.

I understand that this disclosure may involve specific Protected Health Information regarding me. I also understand that authorizing this disclosure is optional and I am not required to sign this authorization.

_____

Applicant's Name (Please Print)

_____

Applicant's Signature Date

_____

Joint Applicant's Name (Please Print)

_____

Joint Applicant's Signature Date

RETURN ONE COPY TO HOME OFFICE, LEAVE ONE COPY WITH APPLICANT(S)