



AMERICAN UNITED LIFE INSURANCE COMPANY®
 PIONEER MUTUAL LIFE INSURANCE COMPANY*
 R.E. MOULTON, INC.
 THE STATE LIFE INSURANCE COMPANY

**Authorization for the Release of Health-Related Information
 (HIPAA-Compliant Form)**

 Name of Proposed Insured/Patient (Please type or print.)

____ / ____ / ____
 Date of Birth

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory, pharmacy or pharmacy benefit manager; medical facility; or other health care provider; insurance company; the MIB, Inc. (formerly known as Medical Information Bureau); or other organization or person that has provided payment, treatment or services to me or on my behalf within the past 10 years or has any records or knowledge of my health within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the partners of OneAmerica Financial Partners, Inc., as listed above. This includes information on the diagnosis or treatment of human immunodeficiency virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that partners of OneAmerica® may:

- 1) underwrite my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
- 2) obtain reinsurance;
- 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
- 4) administer coverage; and
- 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with a OneAmerica financial partner.

This authorization shall remain in force for twenty-four (24) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to:

Attention: Privacy Officer
 OneAmerica Financial Partners, Inc.
 One American Square
 P.O. Box 368
 Indianapolis, Indiana 46206

Please Do Not Send Medical Records, etc. to the Privacy Officer

I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization to disclose information about me or to the extent that OneAmerica partners have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by any OneAmerica partner except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, OneAmerica partner companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

 Signature of Proposed Insured/Patient or Personal Representative

____ / ____ / ____
 Date

 Description of Personal Representative's Authority or Relationship to Patient

**A stock subsidiary of American United Mutual Insurance Holding Company.*