

Authorization for Release of Health-Related Information to:

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| <input type="checkbox"/> ING USA Annuity and Life Insurance Company | <input type="checkbox"/> ReliaStar Life Insurance Company of New York |
| <input type="checkbox"/> Midwestern United Life Insurance Company | <input type="checkbox"/> Security Life of Denver Insurance Company |
| <input type="checkbox"/> ReliaStar Life Insurance Company | <input type="checkbox"/> Southland Life Insurance Company |

This authorization complies with the HIPAA Privacy Rule

Name of Patient (please print)

Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to Patient or on Patient's behalf within the past 10 years ("Providers") to disclose Patient's entire medical record and any other protected health information concerning Patient to "THE COMPANY" and its agents, employees, and representatives. 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 Patient's protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose Patient's entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "THE COMPANY" may: 1) underwrite Patient's application for coverage, make 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 Patient has or has applied for with "THE COMPANY."

This authorization shall remain in force for 30 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 sending a written request for revocation to "THE COMPANY" at 20 Washington Avenue South, Minneapolis, MN 55401, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any Providers have relied on this Authorization or to the extent that "THE COMPANY" has 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 may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the signing of this authorization is not a condition for obtaining treatment or payment for services. I further understand that if I refuse to sign this authorization to release Patient's complete medical record, "THE COMPANY" may not be able to process Patient's application, or if coverage has been issued may not be able to make a claim determination. I acknowledge that I have received a copy of this authorization.

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient