



**AUTHORIZATION FOR RELEASE  
OF HEALTH-RELATED INFORMATION  
TO PEKIN LIFE INSURANCE COMPANY**  
This authorization complies with  
the HIPAA Privacy Rule

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Name of proposed insured/patient (please print)      Date of birth      Social Security Number

I authorize any insurance company, health plan, physician health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit managers, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription drug records and any other protected health information concerning me to the Pekin Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency (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 any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Pekin Life Company may: 1) underwrite my 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 I have or have applied for with Pekin Life Insurance Company.

This authorization shall remain in force for 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 sending a written request for revocation to Pekin Life Insurance Company at 2505 Court Street, Pekin, Illinois 61558-0001, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or the extent that Pekin Life Insurance 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

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, Pekin Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative      Date

\_\_\_\_\_  
Description of Personal Representative's Authority or Relationship to Patient



APPLICATION FOR INSURANCE TO PEKIN LIFE INSURANCE COMPANY

Please Print in Black Ink

PART ONE

Section I Proposed Insured. Name (Last First Middle), (Maiden or former name), Date of Birth (M D Y), Age, Place of Birth, Home Address, City, State, Zip Code, Phone No., Marital Status, Sex, Height, Weight, Social Security No., Occupation or Age Retired.

Section II Applicant. Name of Applicant/Owner (if other than Proposed Insured), Relationship, Social Security # or Taxpayer I.D. #, Address, City, State, Zip.

Section III Beneficiary. Beneficiary (full name), Relationship, Contingent Beneficiary (full name), Relationship.

Section IV Health. Answer Question 1 for Graded Death Benefit Plan - Answer Questions 1 & 2 for Simplified Issue Plan: 1. Are you currently confined to a hospital or hospice... 2. Within the past five years, have you been told you had: A) Any disease or disorder... B) Have you been diagnosed... C) Suffered from... Table with columns: Condition, Date, Degree of Recovery, Doctor's Name and Address.

Section V Policy. PLAN OF INSURANCE Simplified Issue [ ] Graded Death Benefit [ ] Single Premium [ ] 10 Pay [ ] 20 Pay [ ] Life Paid Up at 65 [ ] Full Pay Whole Life [ ] INSURANCE AMOUNT \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_ Mode: Ann [ ] S/A [ ] Qtlly [ ] Mo EFT [ ] Automatic Premium Loan: Yes [ ] No [ ] Do you currently have any existing life insurance coverage or contracts in force? Yes [ ] No [ ] Will the proposed policy replace any existing life insurance or annuity? Yes [ ] No [ ]

This form will authorize any physician, hospital, clinic, pharmacy, pharmacy benefit managers, or other medical or medically-related facility, insurance company, the MIB, Inc., or other organization, institution, or person, who or that has any records, prescription drug records or knowledge of me, my spouse, or children and of their health, to give the Pekin Life Insurance Company or its reinsurers any such information. This information is to be used solely in my application for life and/or health insurance. I authorize Pekin Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of the authorization shall be as valid as the original. Valid for 24 months - I understand I may receive a copy of the authorization.

I declare that I have read and understand all the statements and answers shown in this application, that they are true and complete and correctly recorded whether written by my own hand or not. I further acknowledge that I have read and received the MIB prenotice which was a part of this application.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_ (City, State)

X \_\_\_\_\_ Signature of Proposed Insured X \_\_\_\_\_ Signature of Applicant - if other than Proposed Insured

AGENT'S REPORT

Does the insurance described in this application, to the best of your knowledge, involve the replacement of any existing annuity or life insurance policy ..... Yes [ ] No [ ]

X \_\_\_\_\_ Printed Name of Agent X \_\_\_\_\_ Signature of Agent \_\_\_\_\_ Agent Code

**RECEIPT**

**PEKIN LIFE INSURANCE COMPANY**  
Pekin, Illinois

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_  
for the first premium specified in this application for a Life Contract with Pekin Life Insurance Company which bears the same date as this receipt.

Date \_\_\_\_\_ Agent \_\_\_\_\_

**GIVE TO APPLICANT**

Public Law 91-508, known as the Fair Credit Reporting Act, requires that we advise you that a routine inquiry may be completed which provides applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report will be provided. You may request to be interviewed - if you are not, you may request a copy.

**NOTICE TO APPLICANTS FOR INSURANCE**

Information regarding your insurability will be treated as confidential. Pekin Life Insurance Company or its reinsurers may, however, make a brief report thereon on MIB, a not for profit membership organization of life/health insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information of any information it may have in your file. If you question the accuracy of information in the Bureau file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184, telephone number (866)692-6901, TTY (866)346-3642. We or our reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**NOTICE OF INSURANCE PRACTICE**

The application you completed is our most important source of information. Pekin Life Insurance Company may request information from Physicians who you or one of your family members may have consulted. We may also request information from Insurance Support and Institutional Source organization.

This information may include statements regarding past medical history, current, medical history, current medical conditions and/or prognosis from your Physician. It may also include information concerning character, general reputation, personal characteristics and mode of living. You may request to be interviewed or you may request a copy.

This information may be received through correspondence with your Physician, who may make a report to Pekin Life Insurance Company. Physicians or medically qualified personnel to whom you may be referred for medical examination or other specific medical information, or businesses that engage in Consumer Investigation reports, or other Insurance Companies that you may have applied with during previous insurance negotiations.

Information received during our investigation will be treated as confidential and released to no person or organization without your authorization. Except that Pekin Life Insurance Company may make a brief report to the MIB, Inc., a not for profit membership organization of Life or Health Insurance companies, which operates an information exchange on behalf of its members. We may also provide personal and medical information to Reinsurance Companies for the purpose of purchasing reinsurance over the limits our Company retains.

You have a right to review personal information received during the investigation. You may correct or amend information we received. Reports completed by insurance Support organizations may be retained by that organization and disclosed to other persons.

If you wish to review information we receive for accuracy, send a written request to Pekin Insurance Life Insurance Company. A description of procedures which may allow you access to the information will be provided.