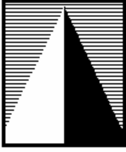

Starmount Life Insurance Company
P. O. Drawer 98100
Baton Rouge, LA 70898-9100

Name:__________________________________

File Number: ____________________________

AUTHORIZATION: I authorize the below-named physician, medical practitioner, hospital, clinic, other medical related facility, or other organization or person that has any records of me, my health, or any member of my family to give Starmount Life or its reinsurers any such information. This includes knowledge about drug abuse, alcoholism, mental illness, and H.I.V. status. Although information about drug and alcohol abuse and H.I.V. status may be protected by government regulation, I allow Starmount to collect it to determine insurability. This authorization is valid for 30 months (in Oklahoma for 24 months), but can be revoked at any time by the applicant's written notification. A copy is as valid as the original. I am also aware that these records may be subject to re-disclosure by the recipient and may no longer be protected. The treatment, payment, enrollment or eligibility for health benefits is not conditioned on your patient signing an authorization.

Medical Practitioner or Facility: ____

Your Physician’s Name: ____

Your Physician’s Address: ____

____

Your Physician’s Telephone Number: _______________________________________

Information to be released: The most recent 2 years from date of last service of all my medical information from your facility, to be used to process a life insurance application.

Your Signature__________________________________ Date____/____/____