Globe Life
Family Heritage Division

Family Heritage Life Insurance Company
PO Box 470608
Cleveland, OH 44147
p: 440-922-5151 f: 440-922 5152

Underwritten by Family Heritage Life Insurance Company, a Globe Life company

Policy Number(s) ______________________ ______________________ ______________________

Statement of Physician

This statement should be completed by the Insured's Primary Care Physician.

Full name of patient?	Name		Age
How long have you treated the patient?			
Were you the patient's medical attendant or adviser before last illness or infirmity? If so, when and for what disease?			
When was the patient diagnosed with the disease or impairment that resulted in death?			
Was the patient ever treated for drug or alcohol abuse? If so, please list dates and locations of treatment.			
Was the patient ever disabled? If so, when and for what reason?			
From what other disease or impairment has the patient suffered, and when?	Disease or Impairment		Duration
Was the patient confined to a hospital during the past 3 years? If so, provide name and address of the hospital.			

Give names and addresses of physicians or other practitioners who, to your knowledge, attended to the deceased during the past five years.

Name	Address	Disease or Impairment

Physician's Name (PRINT) ______________________ Physician's Signature ______________________

Street Address ______________________ City, State, ZIP ______________________

Fax Number ______________________ Phone Number ______________________

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Authorization for Release of Insured's Health Information Pursuant to HIPAA

Insured's Name:	Insured's Date of Birth:	Insured's Social Security Number/Taxpayer ID:
Policy Number:	Policy Number:	Policy Number:
Insured's Address:		

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other insurance company, consumer reporting agency, MIB, Inc., or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the Family Heritage Life Insurance Company (FHL) and its agents, employees, and representatives. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law.

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 FHL 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/or 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with FHL.

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 FHL to the attention of the Underwriting Department at the above address. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization, and that, to the extent that FHL has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent FHL from completing their review of policy claims. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization. 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, FHL may not be able to process my application, or if coverage has been issued, may not be able to process policy claims. I acknowledge that I have received a copy of this authorization.

Name and address of person(s) or category of person to whom this information will be sent:

AI Records/Family Heritage Life
PO Box 2608, Waco, TX 76797
p: 866-922-6453 f: 866-622-6458

If not the patient, name of person signing form:

Authority to sign on behalf of patient:

❑ Parent ❑ Legal Guardian ❑ Next of Kin ❑ Child ❑ Spouse ❑ Executor of Estate

❑ Other (please specify relationship to insured) ______________________________

IMPORTANT: If the patient is deceased, please **INITIAL** one of the statements below:

❑ I am the Administrator/Executor for the deceased and Letters of Testamentary, Executor of Estate documents, or other comparable documentation is enclosed.

❑ There is no court appointed Administrator/Executor and I am the Next of Kin.

All items on this form have been completed and my questions about this form have been answered, and I have been provided a copy of this form.

______________________________ ______________

Signature of patient or personal representative **Date Signed**

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