



May 29, 2003

**To: All Licensed
First United American
Life and Health Agents**

RE: HIPAA Compliant Authorization

The privacy provisions and rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have necessitated the attached authorization form (N3979) which allows First United American to continue to access protected health information from the insured's providers for underwriting purposes on new business and for claims administration. The HIPAA regulation § 164.508 (c)(4) specifically states: "If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization."

This two-part authorization must be used with all life and health sales. Please have the proposed insured sign the form. Send the original back to the home office with the application. Please give the copy of this form to the proposed insured.

Please immediately begin using this HIPAA authorization form (N3979) with all life and health sales. All applications received in the home office July 1, 2003 and after must include form N3979. Please comply with this request to assure timely policy issue and commission payment.

First United American Life Insurance Company

P.O. Box 3125

Syracuse, New York 13220

Authorization for Release of Health-Related Information

This authorization is intended to comply with the HIPAA Privacy Rule

Name of proposed insured/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 me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to the First United American Life Insurance Company (First UA) 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 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 First UA may: 1) underwrite my application(s) 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 First UA.

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 First UA 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 have relied on this Authorization, and that, to the extent that First UA has a legal right to contest a claim under an insurance policy or to contest the policy itself, such revocation may prevent First UA from completing its 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, First UA 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.

Signature of Proposed Insured/Patient or Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

SEND ORIGINAL WITH APPLICATION • GIVE COPY TO PROPOSED INSURED