CLAIM FORM MUST BE COMPLETED IN FULL TO PROCESS THE CLAIM

Authorization to be completed for Death Claim on Life Policy LESS THAN 2 YEARS old

AUTHORIZATIONS FOR NEXT OF KIN

NAMES AND ADDRESSES OF ALL HOSPITALS, PHYSICIANS OR PRACTITIONERS WHO ATTENDED OR PRESCRIBED FOR THE DECEASED WITH 5 YEARS PRECEDING ISSUE DATE OF POLICY:

NAME	ADDRESS	DATES OF ATTENDANCE	DISEASE OR CONDITION

AUTHORIZATION TO RELEASE AND DISCLOSE HEALTH INFORMATION

I, the undersigned individual, hereby request and authorize DIRECTORS LIFE ASSURANCE COMPANY (hereinafter "DLA") to obtain protected health information about _____, a Claimant under a policy for life insurance. Said disclosure of any and all of protected health information of the person whose name appears herein, shall be made to Linda Sargent, Privacy Officer of DLA, for the sole purpose of determining payment on a policy of life insurance. I further request and authorize any and all health care providers, hospitals, clinics and other medical or medically related facility or person with records or knowledge of Claimant's health to release said information in order to assist in claim determination. I acknowledge the receipt of a copy of this Authorization prior to its transmission to you and to DLA. This Authorization shall be in force and effective for twenty (20) days after the date shown below, at which time this Authorization to disclose the protected health information will expire. I understand that I have the right to revoke this Authorization in writing by sending a revocation to the Chief Privacy Officer of DLA, 9020 N. May Avenue, Oklahoma City, Oklahoma 73120. I further understand that any revocation will not be effective until received by DLA. I understand that information used or disclosed relating to this Authorization may be subject to re-disclosure and may no longer be protected by federal or state law.

I understand that I have the right to:

(1) Inspect or copy the protected health information to be used or disclosed as permitted under federal law;

(2) Refuse to sign this Authorization. Refusal to sign this Authorization may prevent DLA from determining whether benefits are payable pursuant to the life insurance policy referenced herein.

_____			
Signature of Next of Kin	Relationship	Social Security Number	Date

or, if Applicable,

_____		
Personal Representative of Insured's Estate	Date of Appointment	Date

THE FURNISHING OF FORMS DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY ON THE PART OF THE COMPANY.