

Information Disclosure – Authorization Supplement to Death Benefit Claim Form

The Serb National Federation (SNF Life) received your submission of a Life Insurance Death Claim Form.

- During our claim process, a consumer investigation report may be obtained that may contain information concerning personal characteristics, mode of living, and/or general reputation. This information may be obtained through personal interviews of your acquaintances, neighbors, and/or friends. Further information, as to the scope of these inquiries, can be provided to you upon a written request to the SNF Life Home Office.
- Any information with respect to the claim process will be treated as confidential. However, we can make a report to the MIB Inc., (MIB is a not-for-profit membership organization of life insurance companies that operates an information exchange on behalf of its members). If an application is made to another MIB member for either life or health insurance coverage; or submitted a claim for benefits to a MIB member; the MIB (upon request) will supply the MIB member with the information, it has on file. The MIB, upon written request from you, will arrange disclosure of any information it may have in your file (medical information will only be disclosed to your attending physician). If you suspect the accuracy of this information is incorrect, you may contact the MIB to seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB is: 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, phone 866-692-6901. We may also release information in our file to other life insurance companies and/or our reinsurer(s) to whom application may be made for life and/or health coverage; or to whom a claim for benefits may be submitted.

A COPY OF THIS NOTIFICATION/AUTHORIZATION MUST BE GIVEN TO THE CLAIMANT WHEN REQUIRED AND A COPY OF THIS FORM (completed) MUST ACCOMPANY THE ORIGINAL LIFE INSURANCE DEATH CLAIM FORM WHEN IT IS SUBMITTED.

I authorize the following that may have any records and/or information regarding me or my minor children, including driving records, controlled substance and/or alcohol use, to provide these records of information to: SNF Life; its legal representative, or its reinsurers:

- Any licensed physician or medical practitioner
- Any hospital or clinic, medical or medically related facility
- The MIB Inc., consumer reporting agency or other such organization, insurer, or reinsurer, employer, institution, government agency, or person

I also authorize that:

- All sources stated above expect the MIB to provide such information to a consumer reporting agency or other agency employed by the SNF to obtain such information.
- The SNF or its reinsurers, to release such information to the MIB, other insurers wherein my minor children and/or myself have insurance, to whom I or they may apply for insurance, or to whom a claim may be submitted; or as may be required by law.
- The SNF to obtain an investigative consumer report.

I understand that:

- Upon request, I or my duly authorized representative may receive a copy of the authorization
- The information obtained by this authorization will be used to determine my eligibility and/or my minor children's eligibility for insurance, or to determine the eligibility for benefits in the event of a claim.
- Any information obtained on the application about a medical consultation or informational visit concerning AIDS or ARC, as opposed to the diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured. I Agree that this authorization or a copy shall be valid for a period of 30 months (If written in the state of INDIANA 24 months) from the date signed below.

Printed Name of Claimant

Signature of Claimant

____/____/____
Date