SHENANDOAH LIFE INSURANCE COMPANY

INDIVIDUAL UNDERWRITING

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO SHENANDOAH LIFE INSURANCE COMPANY

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

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 on my behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning me to Shenandoah Life Insurance Company 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 made to restrict such 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 such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Shenandoah Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage that I have applied for with Shenandoah Life Insurance Company.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that if I reside in Kansas, Kentucky, New Mexico, or Oklahoma, this Authorization shall remain valid for 24 months; and for 26 months if I reside in Minnesota; and, if I reside in Arizona as to HIV-related information only this Authorization shall remain valid for 180 days. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Shenandoah Life Insurance Company at P.O. Box 12847, Roanoke, VA 24029, Attention: Chief Privacy Official. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Shenandoah Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. 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 if I refuse to sign this Authorization to release the complete medical record, Shenandoah Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

_____ _____

Name of Proposed Insured (please print) Date

X_____

Signature of Proposed Insured

_____ _____

Name of Proposed Insured (please print) Date of Birth

TO BE COMPLETED BY AGENT OR HOME OFFICE ONLY