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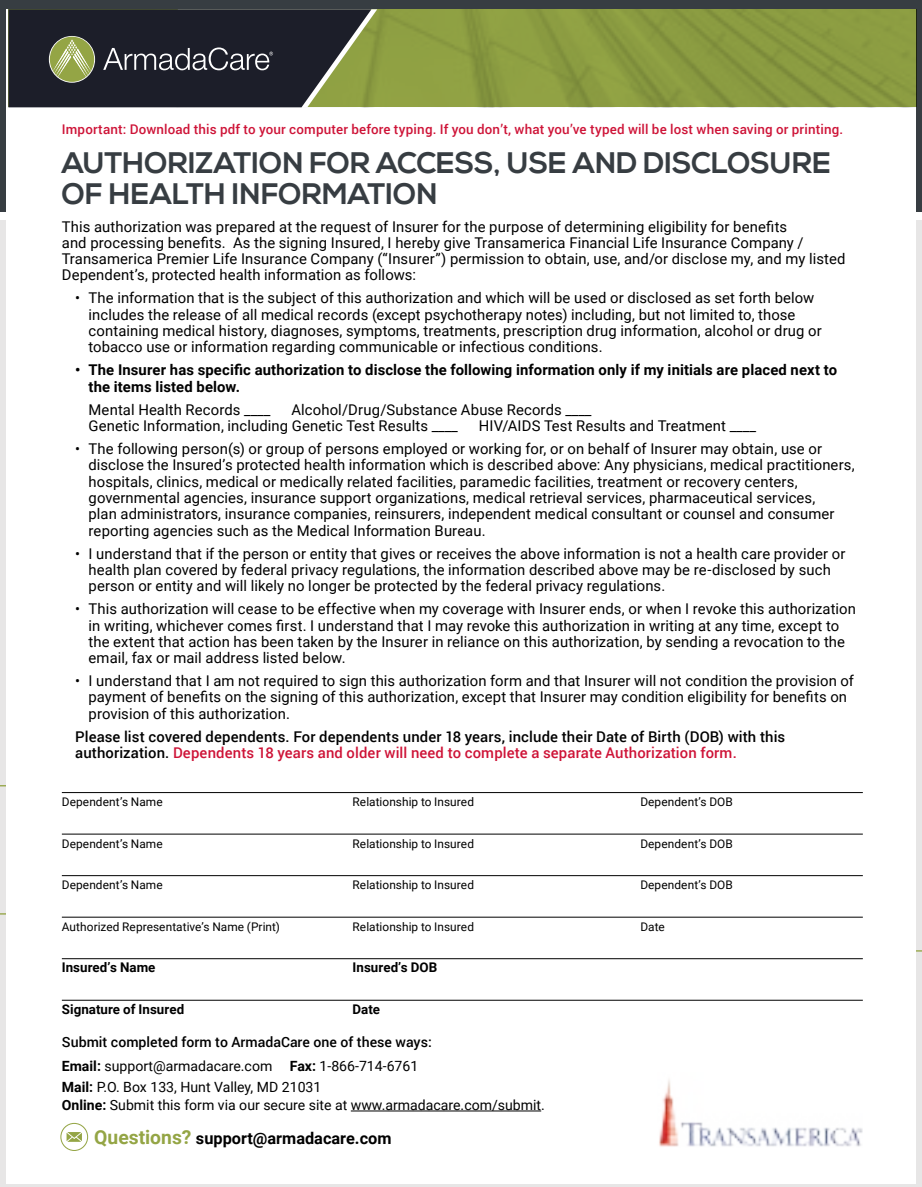
HOW TO FILL OUT YOUR **AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF HEALTH INFORMATION FORM**

By filling out this form on page 2, you give us permission to share your claims information with the person you disclose as the Authorized Representative. This allows you to have someone else (whether a spouse, admin or another trusted party) to manage your claims for you. This form also allows us to share your dependent(s) claims information with the Authorized Representative (if they're under 18). *Please note: Every person over 18 must complete this form as the "Insured."* Do you have questions about why this form is necessary? Please see the FAQ.



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AUTHORIZATION FOR ACCESS, USE AND DISCLOSURE OF HEALTH INFORMATION

This authorization was prepared at the request of Insurer for the purpose of determining eligibility for benefits and processing benefits. As the signing Insured, I hereby give Transamerica Financial Life Insurance Company / Transamerica Premier Life Insurance Company ("Insurer") permission to obtain, use, and/or disclose my, and my listed Dependent's, protected health information as follows:

- The information that is the subject of this authorization and which will be used or disclosed as set forth below includes the release of all medical records (except psychotherapy notes) including, but not limited to, those containing medical history, diagnoses, symptoms, treatments, prescription drug information, alcohol or drug or tobacco use or information regarding communicable or infectious conditions.
- **The Insurer has specific authorization to disclose the following information only if my initials are placed next to the items listed below.**

  Mental Health Records ____ Alcohol/Drug/Substance Abuse Records ____
  Genetic Information, including Genetic Test Results ____ HIV/AIDS Test Results and Treatment ____
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's protected health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- This authorization will cease to be effective when my coverage with Insurer ends, or when I revoke this authorization in writing, whichever comes first. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Insurer in reliance on this authorization, by sending a revocation to the email, fax or mail address listed below.
- I understand that I am not required to sign this authorization form and that Insurer will not condition the provision of payment of benefits on the signing of this authorization, except that Insurer may condition eligibility for benefits on provision of this authorization.

Please list covered dependents. For dependents under 18 years, include their Date of Birth (DOB) with this authorization. Dependents 18 years and older will need to complete a separate Authorization form.

Dependent's Name	Relationship to Insured	Dependent's DOB
Dependent's Name	Relationship to Insured	Dependent's DOB
Dependent's Name	Relationship to Insured	Dependent's DOB
Authorized Representative's Name (Print)	Relationship to Insured	Date
Insured's Name	**Insured's DOB**	
Signature of Insured	**Date**	

Submit completed form to ArmadaCare one of these ways:

Email: support@armadacare.com **Fax:** 1-866-714-6761
Mail: P.O. Box 133, Hunt Valley, MD 21031
Online: Submit this form via our secure site at www.armadacare.com/submit.

Questions? support@armadacare.com

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Only list dependents under 18. If your child (over 18) or spouse wants to assign someone to manage their claims, they must complete their own form as the "Insured."

Who are you assigning to manage your claims? Fill in their name and relationship to you on the Authorized Representative lines.

You are the "Insured": The person authorizing another person (the Authorized Representative) to manage claims, ask questions about claims, etc., on your behalf. Every person over 18 must complete this form as the "Insured."

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  Mental Health Records ____ Alcohol/Drug/Substance Abuse Records ____
  Genetic Information, including Genetic Test Results ____ HIV/AIDS Test Results and Treatment ____
- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's protected health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
- I understand that if the person or entity that gives or receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
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Authorized Representative's Name (Print)	Relationship to Insured	Date
Insured's Name	**Insured's DOB**	
Signature of Insured	**Date**	

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Email: support@armadacare.com **Fax:** 1-866-714-6761

Mail: P.O. Box 133, Hunt Valley, MD 21031

Online: Submit this form via our secure site at www.armadacare.com/submit.

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FAQs ABOUT THIS AUTHORIZATION FORM

FREQUENTLY ASKED QUESTIONS:

What is Protected Health Information (PHI)?

PHI is individually identifiable health information that is or has been maintained or transmitted electronically. This includes medical bills and other claim documentation submitted to ArmadaCare.

Why do I need to complete this form?

If you expect your spouse to contact ArmadaCare to ask about claims status or to follow up on requests for additional documentation, this form gives us your permission to disclose or discuss claims that you have submitted.

Why can't you talk to my provider or my spouse without this form?

Under the Health Information Portability and Accountability Act of 1996 (HIPAA), a health plan must maintain privacy standards for PHI. This means that ArmadaCare cannot talk to anyone except the plan participant about the claims submitted unless we have an authorization form signed by you.

How long will this authorization last?

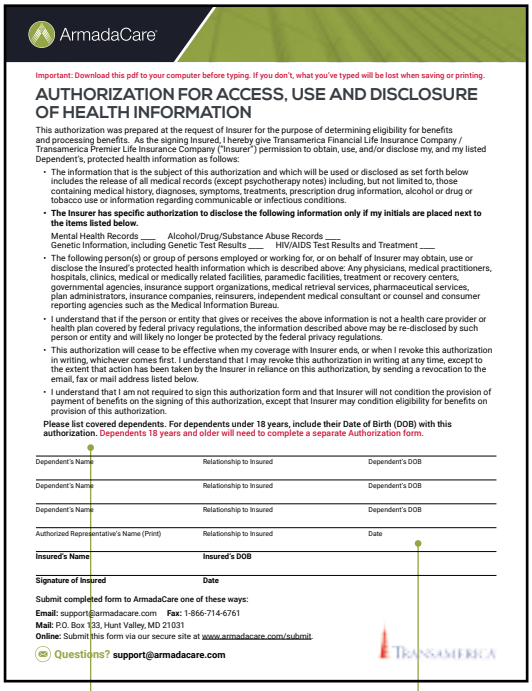
It will remain in effect until coverage with Insurer ends or when authorization is revoked in writing, whichever comes first. If there is a lapse of participation, a new form will be required.

Is there a limited number of authorizations that can be in effect at one time?

No. This form can be submitted for a spouse, a parent, a dependent or an ex-spouse for a child under the age of 18. The number and types of authorizations will depend on the individual family situation.

FORM REMINDER:

Every person over 18 must complete a separate form.



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- The following person(s) or group of persons employed or working for, or on behalf of Insurer may obtain, use or disclose the Insured's protected health information which is described above: Any physicians, medical practitioners, hospitals, clinics, medical or medically related facilities, paramedic facilities, treatment or recovery centers, governmental agencies, insurance support organizations, medical retrieval services, pharmaceutical services, plan administrators, insurance companies, reinsurers, independent medical consultant or counsel and consumer reporting agencies such as the Medical Information Bureau.
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