

SECTION 3: MEDICAL AND ACTIVITIES QUESTIONNAIRE (continued)

Explain any "Yes" answers below. If additional space is necessary, attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

SECTION 4: NOTICE OF EXCHANGE OF INFORMATION

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901. (TTY: 1-866-346-3642 for hearing impaired).

SECTION 5: AGREEMENT AND AUTHORIZATION

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB Group, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I understand that Anthem Life Insurance Company reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

Applicant signature X	Date (MM/DD/YYYY)
Spouse signature (If to be covered) X	Date (MM/DD/YYYY)

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: Anthem, PO Box 182361, Columbus, OH, 43218-2361. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

REFUSAL OF AUTHORIZATION – I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

Applicant signature X	Date (MM/DD/YYYY)
Spouse signature (If to be covered) X	Date (MM/DD/YYYY)

Fraud Warning: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.