State Life Insurance Fund

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873 • Madison WI 53707-7873 • (608) 266-0107 or 1-800-562-5558
oci.wi.gov/slif.htm

HISTORY OF THE FUND

The State Life Insurance Fund (Fund) is a state-sponsored life insurance program for the benefit of residents of Wisconsin.

The Fund is a nonprofit organization and receives no subsidies from the state. It is not permitted to use commissioned agents, does not advertise, and is exempt from federal income tax. As a result, overhead expenses are minimal.

The Fund was established in 1911 in response to a national scandal over the improper practices of some life insurance companies.

According to the Insurance Commissioner at the time, the Fund was set up ". . . to give the people of the state the benefit of the best old-line insurance on a mutual plan at the lowest possible cost."

Originally the maximum level of coverage available to each policyholder was $1,000. This maximum is now $10,000.

TYPES OF LIFE INSURANCE POLICIES

The Fund pays dividends on all the life insurance it issues. The two types are:

TERM INSURANCE

A Term to Age 65 policy is offered by the Fund. The premiums for these policies remain the same until the policy terminates. Term to Age 65 may be converted to any type of whole life insurance prior to age 55. (The Fund does not offer decreasing or annually renewable term policies.)

Term insurance provides death protection for a specific period. Death benefits are paid only if you die within that period. People usually buy term insurance to get the most death protection for their money.

WHOLE LIFE INSURANCE

The Fund offers four different whole life policies. An Ordinary Life policy has premiums paid throughout the life of the policyholder. A Life Paid Up at Age 65 policy has premiums payable to age 65. A 20-Payment Life policy is paid for 20 years. A Single Premium Life policy has one premium paid at the time of issue.

Whole life insurance has lifetime insurance protection for the insured provided the premium is paid.

Whole life policies accumulate a cash value which is returned to you if you surrender the policy. You may borrow against the policy's cash value. If you do, the policy's net value will be reduced proportionately.

Whole life insurance is sometimes bought as an investment. However, very little of your premium will be returned to you if you surrender your policy in the early years. For the first several years, the rate of return on the cash value is low. You should not consider any whole life policy as an investment unless you intend to keep it for twenty years or longer.

APPLICATION PROCESS

ELIGIBILITY

Life insurance policies are only available to persons who are residents of the state of Wisconsin at the time the application is submitted. Proposed insureds must be at least 14 days old.

All five different policies are available to residents who are standard risks. Residents who are substandard risks are only eligible for an Ordinary Life policy.

Underwriting of the applications of substandard risks may require the Fund to seek information from the Medical Information Bureau and/or an investigative consumer report. This information will only be obtained if necessary.

The Fund is not required to provide insurance to all residents who apply. Consequently some substandard risks may not be eligible for insurance from the Fund. The Fund is required to operate in a manner consistent with private insurers with regard to policy coverage, medical examinations, and underwriting procedures.

MEDICAL EXAMINATIONS

The Fund requires a medical exam for applicants who are 55 years of age or older. The Fund may request exams on other applicants. If a medical exam is required or requested, the applicant will be required to see a licensed physician. The Fund will pay a set fee toward the exam cost.

LIFE INSURANCE COSTS

PREMIUM TABLES

The premiums for the standard policies offered by the Fund are given on the following page. To determine your premium, look at your age, sex, and the policy you wish to buy. The rates indicate the cost per $1,000 of insurance. Multiply this rate by the amount of insurance you are buying to determine the actual premium you will pay. If you pay quarterly or semiannually, costs will be somewhat higher. If you can afford to pay premiums annually, you can save this cost.

WAIVER OF PREMIUM BENEFIT

Standard risks who buy life insurance through the Fund automatically have a waiver of premium benefit. This means if total and permanent disability of the insured occurs, premium payments are paid by the Fund and the policy remains in force.

This benefit expires when the insured reaches age 60 unless the insured is disabled.

CASH SURRENDER VALUE

The cash surrender value is the guaranteed amount of cash available in the policy. Cash surrender values are important to policyholders who wish to borrow money or build an asset fund.

Cash surrender values may be borrowed. If you borrow the cash surrender value and die, this amount will be deducted from the benefits paid. The Fund currently charges 8% interest on outstanding loans. If you terminate the policy, you will receive the net cash surrender value. If you would like a printout of cash values for a desired plan, contact the Fund.

OTHER CONSIDERATIONS

Cost is only one consideration in buying life insurance. Consumers should also be concerned about the provisions of the policy contract, the stability of the insurer, and the service received.

APPLICATION INSTRUCTIONS

Instructions for completing the Fund application form are included on the form. However, five important instructions should be noted:

1. All questions in the application must be answered. The processing of the insurance will be delayed with incomplete responses.
2. Enter the total annual premium on the application. For a $5,000 policy, the annual premium will be five times the rate per $1,000, etc. This must be entered on the application form even if you are paying quarterly or semiannually.
3. State the full name of all beneficiaries. Do not list beneficiaries as “my wife,” “my spouse,” or “Mrs. Brown.”
4. If the person to be covered by the insurance is under age 18, an owner must be designated.
5. Mail the application form and premium to:

State Life Insurance Fund

P.O. Box 7873

Madison, WI 53707-7873.

PRE NOTICE—DISCLOSURE OF INFORMATION

State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or 1-800-562-5558
Fax: (608) 264-6220
ocislif@wisconsin.gov
oci.wi.gov/slif.htm

We, or our reinsurers, may make a brief report to the MIB, Inc. MIB, Inc., is a not-for-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, upon request will supply the company with the information in its file. At your request, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB's file, you may contact MIB and seek 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. The telephone number is 866-692-6901. Information for consumers about MIB, Inc., may be obtained on its website at www.mib.com.

LIFE INSURANCE ANNUAL PREMIUMS PER $1,000

INCLUDES WAIVER OF PREMIUM BENEFIT AT APPLICABLE AGES
MALE PREMIUMS

Issue Age	OL Ordinary Life	20P Twenty Pay Life	L65 Life Paid Up at Age 65	T65 Term to Age 65	SP Single Premium Life
0	8.26	10.68	8.39	N/A	120.67
1	8.37	10.85	8.50	N/A	123.07
2	8.47	11.03	8.62	N/A	125.65
3	8.57	11.21	8.73	N/A	128.30
4	8.67	11.39	8.84	N/A	131.00
5	8.77	11.57	8.95	N/A	133.76
6	8.89	11.79	9.10	N/A	136.78
7	9.02	12.01	9.24	N/A	139.86
8	9.15	12.22	9.39	N/A	143.01
9	9.27	12.44	9.53	N/A	146.22
10	9.39	12.67	9.67	N/A	149.48
11	9.56	12.93	9.86	N/A	153.10
12	9.72	13.20	10.05	N/A	156.77
13	9.88	13.46	10.24	N/A	160.49
14	10.03	13.71	10.42	N/A	164.22
15	10.17	13.96	10.59	7.19	167.92
16	10.35	14.24	10.81	7.26	171.95
17	10.52	14.51	11.02	7.30	175.90
18	10.70	14.78	11.24	7.34	179.74
19	10.87	15.05	11.45	7.37	183.65
20	11.04	15.32	11.67	7.40	187.63
21	11.25	15.63	11.93	7.45	191.99
22	11.46	15.94	12.20	7.50	196.44
23	11.67	16.25	12.48	7.54	200.98
24	11.88	16.57	12.76	7.58	205.63
25	12.10	16.89	13.06	7.63	210.37
26	12.36	17.26	13.41	7.69	215.56
27	12.63	17.64	13.77	7.76	220.91
28	12.91	18.03	14.16	7.83	226.43
29	13.21	18.43	14.56	7.91	232.14
30	13.50	18.84	14.99	7.99	238.02
31	13.86	19.31	15.49	8.11	244.33
32	14.23	19.78	16.01	8.22	250.79
33	14.60	20.26	16.56	8.32	257.37
34	14.98	20.75	17.14	8.43	264.10
35	15.38	21.24	17.75	8.52	270.95
36	15.84	21.80	18.45	8.65	278.15
37	16.31	22.37	19.19	8.76	285.47
38	16.80	22.94	19.97	8.87	292.90
39	17.31	23.53	20.81	8.97	300.46
40	17.83	24.12	21.71	9.06	308.15
41	18.34	24.74	22.67	9.18	316.04
42	18.88	25.38	23.70	9.30	324.09
43	19.44	26.04	24.83	9.42	332.31
44	20.02	26.72	26.07	9.56	340.78
45	20.64	27.44	27.44	9.71	349.49
46	21.29	28.15	28.95	9.85	358.45
47	21.97	28.89	30.64	10.00	367.68
48	22.69	29.67	32.52	10.18	377.17
49	23.45	30.48	34.63	10.37	386.95
50	24.25	31.32	37.01	10.58	397.00
51	25.07	32.13	39.67	10.88	407.39
52	25.93	32.97	42.74	11.21	418.03
53	26.83	33.84	46.29	11.56	428.90
54	27.78	34.75	50.46	11.93	440.00
55	28.77	35.70	55.43	12.33	451.33
56	29.68	36.46	N/A	N/A	462.98
57	30.63	37.24	N/A	N/A	474.85
58	31.61	38.05	N/A	N/A	486.90
59	32.64	38.90	N/A	N/A	499.12
60	33.70	39.78	N/A	N/A	511.49
61	35.29	41.18	N/A	N/A	524.22
62	36.97	42.65	N/A	N/A	537.06
63	38.75	44.21	N/A	N/A	550.00
64	40.65	45.87	N/A	N/A	563.01
65	42.67	47.65	N/A	N/A	576.09
66	45.15	49.76	N/A	N/A	589.58
67	47.83	52.06	N/A	N/A	603.18
68	50.73	54.55	N/A	N/A	616.88
69	53.86	57.29	N/A	N/A	630.67
70	57.24	60.28	N/A	N/A	644.51
71	N/A	N/A	N/A	N/A	659.39
72	N/A	N/A	N/A	N/A	674.26
73	N/A	N/A	N/A	N/A	689.05
74	N/A	N/A	N/A	N/A	703.73
75	N/A	N/A	N/A	N/A	718.26
76	N/A	N/A	N/A	N/A	733.92
77	N/A	N/A	N/A	N/A	749.50
78	N/A	N/A	N/A	N/A	765.00
79	N/A	N/A	N/A	N/A	780.42
80	N/A	N/A	N/A	N/A	795.73

INCLUDES WAIVER OF PREMIUM BENEFIT AT APPLICABLE AGES
FEMALE PREMIUMS

Issue Age	OL Ordinary Life	20P Twenty Pay Life	L65 Life Paid Up at Age 65	T65 Term to Age 65	SP Single Premium Life
0	7.89	9.99	8.01	N/A	110.58
1	7.98	10.15	8.11	N/A	112.61
2	8.07	10.30	8.21	N/A	114.86
3	8.16	10.47	8.31	N/A	117.22
4	8.25	10.62	8.41	N/A	119.62
5	8.33	10.78	8.51	N/A	122.06
6	8.45	10.97	8.64	N/A	124.74
7	8.56	11.16	8.77	N/A	127.46
8	8.67	11.36	8.90	N/A	130.25
9	8.78	11.55	9.02	N/A	133.08
10	8.89	11.74	9.15	N/A	135.96
11	9.03	11.97	9.31	N/A	139.14
12	9.17	12.21	9.48	N/A	142.38
13	9.32	12.44	9.65	N/A	145.71
14	9.45	12.67	9.81	N/A	149.08
15	9.58	12.89	9.97	6.66	152.44
16	9.74	13.15	10.17	6.70	156.12
17	9.90	13.40	10.37	6.73	159.80
18	10.06	13.66	10.57	6.76	163.53
19	10.23	13.92	10.77	6.80	167.35
20	10.39	14.19	10.98	6.83	171.27
21	10.59	14.49	11.24	6.88	175.53
22	10.79	14.80	11.50	6.94	179.91
23	11.00	15.11	11.76	6.98	184.39
24	11.20	15.42	12.03	7.02	188.94
25	11.41	15.73	12.31	7.05	193.57
26	11.66	16.09	12.65	7.11	198.61
27	11.91	16.45	12.99	7.18	203.77
28	12.17	16.83	13.35	7.24	209.07
29	12.43	17.20	13.73	7.30	214.49
30	12.70	17.59	14.12	7.35	220.04
31	13.02	18.01	14.57	7.44	225.96
32	13.34	18.45	15.05	7.52	232.01
33	13.68	18.90	15.55	7.60	238.20
34	14.02	19.35	16.08	7.67	244.53
35	14.37	19.81	16.63	7.73	250.96
36	14.77	20.32	17.27	7.82	257.74
37	15.20	20.84	17.95	7.89	264.65
38	15.63	21.37	18.67	7.96	271.68
39	16.07	21.92	19.44	8.03	278.84
40	16.54	22.48	20.27	8.09	286.17
41	17.01	23.08	21.17	8.18	293.86
42	17.51	23.70	22.16	8.27	301.76
43	18.02	24.34	23.23	8.36	309.87
44	18.56	25.00	24.40	8.47	318.20
45	19.12	25.68	25.69	8.57	326.75
46	19.73	26.39	27.13	8.74	335.67
47	20.36	27.11	28.72	8.91	344.79
48	21.02	27.85	30.49	9.08	354.12
49	21.71	28.62	32.47	9.26	363.65
50	22.42	29.42	34.70	9.44	373.39
51	23.16	30.18	37.24	9.72	383.49
52	23.93	30.97	40.16	10.01	393.82
53	24.74	31.79	43.54	10.31	404.35
54	25.58	32.63	47.51	10.63	415.08
55	26.46	33.50	52.24	10.97	426.02
56	27.26	34.20	N/A	N/A	437.34
57	28.09	34.91	N/A	N/A	448.85
58	28.96	35.65	N/A	N/A	460.56
59	29.85	36.41	N/A	N/A	472.45
60	30.78	37.20	N/A	N/A	484.52
61	32.09	38.35	N/A	N/A	496.89
62	33.47	39.56	N/A	N/A	509.41
63	34.93	40.83	N/A	N/A	522.06
64	36.48	42.17	N/A	N/A	534.83
65	38.11	43.60	N/A	N/A	547.69
66	40.24	45.42	N/A	N/A	560.88
67	42.52	47.38	N/A	N/A	574.14
68	44.96	49.48	N/A	N/A	587.46
69	47.58	51.76	N/A	N/A	600.83
70	50.40	54.23	N/A	N/A	614.23
71	N/A	N/A	N/A	N/A	628.45
72	N/A	N/A	N/A	N/A	642.73
73	N/A	N/A	N/A	N/A	657.05
74	N/A	N/A	N/A	N/A	671.40
75	N/A	N/A	N/A	N/A	685.76
76	N/A	N/A	N/A	N/A	701.37
77	N/A	N/A	N/A	N/A	716.96
78	N/A	N/A	N/A	N/A	732.51
79	N/A	N/A	N/A	N/A	748.00
80	N/A	N/A	N/A	N/A	763.39

APPLICATION FOR INSURANCE

Ref: Ch. 607, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or 1-800-562-5558

For office use only: Cash with Application $_____ Date Received_____Policy Number _____

INSTRUCTIONS: Print in ink or type all information, sign form, and forward to above address. All questions must be answered. Only Wisconsin residents are eligible to apply for this insurance. The Fund is NOT required to provide insurance to all applicants.

A. Proposed Insured Information

1. **Proposed Insured's Name** First	Middle	Last		
2. **Resident Address**	City	State	Zip Code	
3. **Sex** ☐ Male ☐ Female	4. **Age**	Date of Birth	5. **State of Birth**	6. **Phone**	7. **Email**
8. **Social Security # of Insured**	9. **Occupation**	10. **Employer**		
11. **Employer Address**	City	State	Zip Code	
12. **Who will be paying for this policy?** Name	Last 4 digits of SSN			
Address	City	State	Zip Code	

B. New Business Product and Benefit Information

1. Complete the amount of coverage and premium for the plan of insurance you desire. Maximum coverage amount is $10,000.

Face Amount of Insurance	Annual Premium
$_____Ordinary Life	$_____Premium Amount
$_____20-Payment Life	$_____Premium Amount
$_____Life Paid Up at Age 65	$_____Premium Amount
$_____Term to Age 65	$_____Premium Amount
$_____Single Premium Life	$_____Total Premium

2. How do you wish to pay premium? (Not applicable to Single Premium Life) If amount is less than $10, you MUST pay annually.
   ☐ Annually ☐ Semiannually (Annual x .51)
   ☐ Quarterly (Annual x .26)
3. Amount of premium enclosed $_____
   Premium method may be changed only on the policy anniversary date. The Automatic Premium Loan provision is effective on all Fund policies.
4. Dividends are to be:
   ☐ Applied to reduce premium ☐ Left to accumulate interest
   ☐ Paid in cash
   Unless otherwise specified, dividends will be applied to reduce the premium.

C. Ownership Information

A minor (under age 18) may not be the owner.

1. Will the Proposed Insured be the Sole Owner of the new policy? ☐ Yes ☐ No
   If yes, proceed to Section D, Beneficiary Information.

2. **Policy Owner**

First Name	Middle Initial	Last Name	
Address	City	State	Zip Code
Relationship to Insured	Date of Birth	Social Security # of Owner	

3. **Contingent Owner**

First Name	Middle Initial	Last Name	
Address	City	State	Zip Code
Relationship to Insured	Date of Birth	Social Security # of Contingent Owner	

4. **Ownership will pass to the Proposed Insured at:**

☐ Age 25 ☐ Other _____

Insured will become owner at Death of all prior owners unless noted above.

D. Beneficiary Information

The beneficiary stated below will receive the policy proceeds upon the insured's death.

1. Who do you wish to name as Primary Beneficiary?

First Name	Middle Initial	Last Name	
Address	City	State	Zip Code
Relationship to Insured	Date of Birth	Social Security Number	

2. If the Primary Beneficiary does not survive you, who do you wish the policy proceeds payable to as Contingent Beneficiary?

First Name	Middle Initial	Last Name	
Address	City	State	Zip Code
Relationship to Insured	Date of Birth	Social Security Number	

☐ Additional Beneficiary information provided on a separate page.

Unless other instructions are given, when more than one First Beneficiary or Contingent Beneficiary is named, all proceeds payable will be shared equally by the First Beneficiary who survive you, or if none, then those Contingent Beneficiaries who survive you. Should no Beneficiaries survive you, proceeds will be payable to the Owner's Estate.

E. Declaration of Insurability

	Yes	No
1. Are you now in good health? If "No," explain below.....	☐	☐
2. Have you ever applied for life or health insurance which was declined, postponed, or modified in any way? If "Yes,"give details below.....	☐	☐
3. In the past three years have you engaged in skydiving, parachuting, racing, underwater diving, or any hazardous sport or hobby?.....	☐	☐
4. Do you use or have you used narcotics or other drugs, including alcohol, which may be habit forming? If "Yes," explain.....	☐	☐
5. Have you received a conviction for Operating While Intoxicated (OWI) within the last 5 years?.....	☐	☐
6. Have you received 3 or more traffic violations in the last 24 months?.....	☐	☐
7. Do you have a family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disorder, mental illness or suicide? If "Yes," give details below.....	☐	☐
8. Do you smoke cigarettes? If "Yes," state daily usage. ..... Amount Per Day_____	☐	☐
9. Are you a pilot or crew member or do you contemplate participation in aviation other than as a fare-paying passenger?	☐	☐
10. Do you have any policies on your life in the State Life Insurance Fund? (Policy Number_____).....	☐	☐
11. Will the State Life Insurance Fund coverage applied for in this application replace any existing life insurance? If "Yes," list policy number and company.....	☐	☐

_____

Company Policy Number

☐ Additional Explanations provided on separate page.

F. Declaration of Insurability– Medical

1. To the best of your knowledge and belief, have you ever had, been treated for, or been told that you have:

	Yes	No
a. Heart trouble, high blood pressure, varicose veins, hemorrhoids, or other disorder of the circulatory system?	☐	☐
b. Diabetes, goiter, or any disorder of the glands?	☐	☐
c. Epilepsy, fainting attacks, mental disorders, or other disorder of the brain or nervous system?	☐	☐
d. Cancer, tumor, syphilis, or tuberculosis?	☐	☐
e. Tested positive for HIV in an FDA-licensed test? (NOTE: Disclosure of a positive test result at an anonymous or alternate test site or home test kits is not required.)	☐	☐
f. Asthma, pleurisy, or other disorder of the respiratory system?	☐	☐
g. Neck or back strain, injury, or hernia?	☐	☐
h. Are you currently taking any type of medication?	☐	☐
i. Ulcer, disorder of stomach, intestines, liver, or gall bladder?	☐	☐
j. Sugar in urine, kidney trouble, or other disorder of the genitourinary tract?	☐	☐
k. Arthritis, rheumatism, or other disorder of the bones, joints, or muscles?	☐	☐
l. Psychiatric, psychological, alcohol, and/or drug treatment?	☐	☐
m. Impairment of sight, speech, hearing, or any disorder of the eye, ear, nose, or throat?	☐	☐
n. Surgical operation performed or been advised to have performed?	☐	☐
o. Medical advice, examination, hospitalization, consultation, or treatment during the past 5 years not previously mentioned?	☐	☐

Give details for each "Yes" response above: [Attach Additional Page(s) as Needed.]	Date Occurred	Duration	Degree of Recovery	Physician's Name and Address for Condition
Question No. Condition				

2. Name of Present Doctor	Clinic Name	Proposed Insured's Height	Proposed Insured's Weight lbs.
Street Address	City State Zip Code		Weight One Year Ago lbs.

3. Father of Proposed Insured's Name	Mother of Proposed Insured's Name
Father of Proposed Insured's Address	Mother of Proposed Insured's Address
If Deceased, Cause of Death and Age at Death	If Deceased, Cause of Death and Age at Death

G. Agreement and Signature

PLEASE READ THIS STATEMENT BEFORE SIGNING

I hereby declare that all answers and statements in this application are complete and true to the best of my knowledge and belief, and I hereby agree that all answers to such questions together with this agreement shall be attached to and form a part of my policy which is issued hereunder. FURTHER, I AGREE THAT INSURANCE APPLIED FOR HEREIN SHALL NOT BE IN FORCE AND EFFECTIVE UNTIL THE POLICY IS ISSUED DURING MY LIFETIME. The policy shall take effect as of the Policy Date specified by the Fund in the policy.

It is required of all insurers to consider whether the purchase of new life insurance suits the needs and means of applicants. If you are satisfied that in consideration of your present life insurance and income the insurance for which you are applying is suitable for your needs, please read and sign the following statement.

I HAVE CONSIDERED MY PRESENT LIFE INSURANCE COVERAGE AND MY INCOME AND FEEL THAT THE INSURANCE FOR WHICH I AM APPLYING THROUGH THE STATE LIFE INSURANCE FUND OF THE STATE OF WISCONSIN IS SUITABLE FOR ME.

Signature of Proposed Insured

Signature of Parent or Guardian (If Proposed Insured Under Age 18)

Signature of Owner (If Designated in C No. 1)

DATED AT , WISCONSIN

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

State Life Insurance Fund
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0107 or (800) 562-5558
Fax: (608) 264-6220
ocislif@wisconsin.gov
oci.wi.gov/Pages/Funds/SLIFOverview.aspx

I understand that information obtained by this Authorization will be used by the State Life Insurance Fund of Wisconsin to determine eligibility for insurance or eligibility for benefits under an existing policy. Failure to authorize the release of this information may result in the State Life Insurance Fund's inability to issue or modify a life insurance contract.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, MIB, Inc., organization, institution or person that has pertinent records or knowledge of me, my spouse, or my minor or dependent children's health and health care, to release that information to the State Life Insurance Fund of Wisconsin or its reinsurers any and all such relevant information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any, in any form, including, but not limited to, original, electronic, or photographic copies. The information is being released in connection with an application filed with the State Life Insurance Fund by, or on behalf of, the undersigned applicant. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody of HIV or what the results of this test were, if obtained by an individual. I authorize the State Life Insurance Fund or its reinsurers to make a brief report of my protected health information to MIB.

I further authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, organization, institution that has any health records regarding me, my spouse, or my minor or dependent children, to release any and all such information or records pertaining to drug or alcohol abuse or mental illness diagnosis or treatment to the State Life Insurance Fund.

I understand that I may revoke this Authorization by providing advance written notice of termination to the State Life Insurance Fund. Any information released prior to the receipt of the revocation that were made in reliance upon this Authorization cannot be retrieved nor can persons employed by the State Life Insurance Fund be held responsible or liable for such release when the release was performed in accordance with the Authorization of state law.

I understand that there is a potential for information disclosed pursuant to this Authorization to be redisclosed by the State Life Insurance Fund pursuant to state law or as needed for evaluation [i.e., to my authorized representative(s), providers, insurers, third-party administrators, or as required by law]. Since information may need to be redisclosed, there is a chance that the information re-released by the State Life Insurance Fund might not be protected by the HIPAA Privacy Regulations.

I acknowledge that I will receive a copy of this Authorization to Obtain Medical Information.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signature of Applicant (or parent or guardian of proposed insured)	Date of Birth	Date Signed