AUTHORIZATION TO DISCLOSE INFORMATION

Important Information: Completion of this consent form is entirely voluntary and is not required as part of your application for insurance. A photocopy or scanned copy of this consent is as valid as the original.

Name of Applicant:
Date of birth:
Insurance application number:
Name of Recipient: Leo Penney

Applicant's consent provided by signing this form
I authorize Co-operators Life Insurance Company ("**Co-operators Life**") to provide to the Recipient personal information collected on the above noted application or during the evaluation or underwriting process that may affect the rating or issuance of the policy, including but not limited to:

- results of medical/laboratory testing
- personal health information, including illnesses or particular medical conditions such as: mental illness, infectious diseases, medication usage, drug and alcohol usage including treatment or rehabilitation programs
- information about your health discovered when your application was assessed, even if not known to you at the time of application
- employment history and information about your personal finances
- records of criminal activity
- other facts about your life and how they might affect your application for insurance

(collectively "**Personal Information**")

Agreement and signature
I authorize Co-operators Life to release the Personal Information described above to the Recipient to assist me in understanding factors relevant to my insurability. I may withdraw this consent at any time by sending a written request to Co-operators Life by fax or mail. **Unless withdrawn earlier, this authorization will expire thirty (30) days from the date I sign it.** I acknowledge that Co-operators Life reserves the right to limit what Personal Information will be shared with the Recipient**. I acknowledge that the recipient is not a representative or agent of Co-operators Life and this document does not create such a relationship.** This authorization will not be effective until signed by both the Applicant and the Recipient and delivered to Co-operators Life.

Signature of Applicant: _____ Date: _____

Recipient's duty of confidentiality to the Applicant
I agree to comply with all requirements of applicable privacy laws and shall protect and safeguard any and all Personal Information which is disclosed by Co-operators Life to me under this authorization. I will not use any Personal Information in a manner inconsistent with the intentions of this authorization and shall not disclose any Personal Information to a third party without prior written authorization from the Applicant.

Signature of Recipient: _____ Date: _____

Co-operators Life Insurance Company - Underwriting Department
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