Madison National Life

Insurance Company, Inc.

P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ Date of birth: _____ Telephone number: _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

5) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: Madison National Life Insurance Company (address, telephone and fax number documented above)

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2009 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2009 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form.

Signature _____ Date _____