Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0058 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE AND DISABILITY INCOME INSURANCE ENROLLMENT

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number 01-018070-00 / Idaho AGC Health Benefit Plan.

Employer/Policyholder Name _____

Street Address _____ City _____ State _____ Zip Code _____

Employee Occupation/Job Title _____ Employee Date of Employment _____

☐ Full Time Employee ☐ Part Time Employee

Effective Date of Coverage _____

$_____/ ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Social Security Number _____

Reason for Enrolling _____

I. EMPLOYEE/ENROLLEE INFORMATION

Name _____ Sex ☐ M ☐ F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____ Marital Status _____

II. BENEFITS (Please check if you wish to enroll)

	Y	No	Indicate the benefit amount
Employee Life	X		$25,000 Flat Amount – Employer Paid
Employee AD&D	X		$25,000 Flat Amount – Employer Paid
Basic Spouse Life	X		$5,000 Flat Amount – Employer Paid
Basic Child Life	X		$5,000 Flat Amount – Employer Paid
Core Short-Term Disability Income Insurance	X		$125 Flat Amount – Employer Paid
*Employee Supplemental Life (Select one)			$25,000 or $50,000 or $75,000 or $100,000
Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.			
Dependent Supplemental Life			
**Spouse[2]			$ _____ (In $5,000 Increments)
Child[2]			$2,000 Flat Amount
Buy Up Short-Term Disability Income Insurance			
➢ Option 1			$325 Flat Amount includes Basic
➢ Option 2			$525 Flat Amount includes Basic

*New hires -> For Employee Supplemental Life, employee may elect in increment of $25,000 up to a maximum of $100,000 without evidence of insurability.

-> **For Dependent Spouse Supplemental Life coverage, employee may elect in increments of $5,000, up to a maximum of $50,000; not to exceed 50% of the Employee Supplemental Life benefit amount.

*During annual modified open enrollment –> For Employee Supplemental Life, employee may increase the current coverage by one increment without Evidence of Insurability.

->** For Dependent Spouse Supplemental Life coverage, employee may increase the current coverage by one increment without Evidence of Insurability

[2] ***List Dependents' names and birthdates (use another page if needed).***

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the Policyholder pays 100% of the required contribution).**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Enrollee/Employee Signature

Date Signed

Group Benefits are insured by Symetra Life Insurance Company.

SYMETRA
RETIREMENT | BENEFITS | LIFE

Evidence of Insurability for Group Coverage Applicants Residing in Idaho

Instructions

Employer/Policyholder Please complete Page 2 and provide to the employee/applicant to complete.

Employee/Applicant Please complete page 3, sign and date page 4 and an "Authorization for Release of Medical Information" form. If applying for spouse coverage, have your spouse complete page 6, sign and date page 7 and an "Authorization for Release of Medical Information" form. Return to Symetra for processing.

Two copies of the 'Authorization for Release of Medical Information' form are included in the back of this packet. One for you and one for your spouse, if applicable.

Completed forms can be mailed or faxed to:
Symetra Life Insurance Company
PO Box 34690
Seattle, WA 98124-1690

Fax: 1-866-348-0058

Comments

SYMETRA
RETIREMENT | BENEFITS | LIFE

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EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

Policyholders: Completely fill out Sections 1 – 3 and forward to the applicant to complete, sign and return to Symetra.

Section 1: Group Plan Details *(to be completed by Policyholder)*

Company name (policyholder)	Policy number 01-018070-00
Division or associated company (if applicable)	
Company mailing address (street, city, state, zip code)	
Benefits contact name (first, last)	
Benefits contact email address	Benefits contact phone (include area code)

Section 2: Applicant Details *(to be completed by Policyholder)*

Name of applicant	Date of hire (mm/dd/yyyy)
Class	Basic Annual Earnings*

*****As described in the group policy

Section 3: Coverages Requested *(to be completed by Policyholder)* ***Check all that apply***

Coverage (Check all that apply)	Current amount of coverage (including GI** amount)	Additional coverage requested	Total coverage amount
(Example for Life Policies)	$25,000	$100,000	$125,000
☑ Applicant: Basic Life	$25,000	$0	$25,000
☐ Applicant: Supplemental or Voluntary Life			$0
☑ Spouse: Basic Life	$5,000	$0	$5,000
☐ Spouse: Supplemental or Voluntary Life			$0
☑ Child: Basic Life	$5,000	$0	$5,000
☐ Child: Supplemental or Voluntary Life			$0

☑ Applicant: Short Term Disability	☑ Yes	☐ No
☐ Applicant: Voluntary Short Term Disability	☐ Yes	☐ No
☐ Applicant: Long Term Disability	☐ Yes	☑ No
☐ Applicant: Voluntary Long Term Disability	☐ Yes	☑ No

**Guarantee Issue (GI) is the maximum amount of coverage defined by the group policy that does not require evidence of insurability.

Section 4: Applicant Information *(to be completed by applicant)*

Applicant name (first, last)	Gender ☐ Male ☐ Female
Applicant address (street, city, state, zip code)	

Date of birth	Height	Weight	Driver License number	Email address

State of birth	Day phone (include area code)	Evening phone (include area code)

How may we best contact you?
Symetra offers secure e-mail for the quickest turnaround time ☐ Mail ☐ Email ☐ Day phone ☐ Evening phone

Full name, address and phone of your personal physician

Section 5: Applicant Health Information *(to be completed by applicant)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? ☐ Yes ☐ No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**
   - a) ☐ Heart Disease or Disorder
   - b) ☐ Bipolar Disorder, Major Depressive Disorder, or Schizophrenia
   - c) ☐ Alcoholism and/or Drug Use
   - d) ☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
   - e) ☐ Stroke, Paralysis
   - f) ☐ Multiple Sclerosis, ALS (Lou Gehrig's Disease)
   - g) ☐ Type I/Insulin-Dependent Diabetes
   - h) ☐ Grand Mal Epilepsy or Generalized Seizures
   - i) ☐ Hepatitis B or C
   - j) ☐ Cirrhosis of the liver
3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 6.**
   - k) ☐ Non-Insulin Dependent/ Type II Diabetes
   - l) ☐ Mental & Nervous Disorder; Depression/Anxiety
   - m) ☐ Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy
   - n) ☐ Liver Disorder
   - o) ☐ Kidney Disorder
   - p) ☐ Blood Disorder
   - q) ☐ Stomach, Abdominal, Intestinal Disorder
   - r) ☐ Bone, Joint, Connective Tissue Disorder
   - s) ☐ Cancer, Tumors
   - t) ☐ Gland Disorder
   - u) ☐ Lungs, Respiratory Disorder
4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes ☐ No
   If yes, please indicate condition and provide details in the Health Information Section.

Section 6: Applicant Health Information *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset Mo. Yr.	Duration	Degree of recovery	Name/address/phone of attending physician

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset Mo. Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of applicant	Date

Print name

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

Disclosure Notice to Applicants for Insurance

This brief description of our underwriting process is designed to help you to understand how an application for insurance is handled, the type and sources of information we may collect about you, the circumstances under which we may disclose that information to others and your right to learn the nature and substance of that information upon written request. Your medical history and current physical condition, which is obtained from various sources, are factors, which are considered in determining your insurability.

Sources of Information:

Your application, including the medical history, is a primary source of information in the evaluation process. We may also ask for a report from your doctor, hospital, pharmacy, pharmacy benefit manager or another insurance company. When we do so, we use the authorization form you sign with your application. It is sometimes necessary that we ask you to take a physical examination or other special tests such as an electrocardiogram and/or blood test.

Disclosure to Others:

Personal information obtained about you during the underwriting process is confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary for the conduct of our business. Examples of situations where we share information about you are as follows:

1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

Disclosure to You:

If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

Symetra Life Insurance Company respects your right to the privacy of your personal information. This notice is provided to you to help you understand that information, which is obtained, is treated in a confidential manner. You have a right of access and correction with respect to all personal information collected. Upon written request, we will provide you with a more detailed description of our information practices and your rights of access and correction.

**For residents of Louisiana and Massachusetts only:*

Medical record information will be given to a medical professional designated by you and licensed to provide the kind of medical care in question or, if you prefer, to you directly. Mental health record information will be given directly to you only with the approval or the professional who has treatment responsibility for the condition in question.

Please read the following notice that we are required by law to give to you.

For all states not named: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NH: 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 RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 7: Spouse or Domestic Partner or Civil Union Partner Information

(to be completed by the Spouse or Domestic Partner or Civil Union Partner (if applicable))

Spouse/Domestic Partner name (first, last)	Gender ☐ Male ☐ Female

Address (street, city, state, zip code)

Date of birth	Height	Weight	Drivers license number	Email address

State of birth	Day phone (include area code)	Evening phone (include area code)

How may we best contact you?

Symetra offers secure e-mail for the quickest turnaround time ☐ Mail ☐ Email ☐ Day phone ☐ Evening phone

Full name, address and phone of your personal physician

Section 8: Spouse or Domestic Partner or Civil Union Partner Health Information *(to be completed by the applicable person)*

The following health questions must be answered fully and truthfully to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

1. Are you pregnant? ☐ Yes ☐ No **If yes, please give details in the Health Information Section including due date.**
2. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

a) ☐ Heart Disease or Disorder
b) ☐ Bipolar Disorder, Major Depressive Disorder, or Schizophrenia
c) ☐ Alcoholism and/or Drug Use
d) ☐ Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection/Disease, or tested Positive to the AIDS virus (HIV)
e) ☐ Stroke, Paralysis
f) ☐ Multiple Sclerosis, ALS (Lou Gehrig's Disease)
g) ☐ Type I/Insulin-Dependent Diabetes
h) ☐ Grand Mal Epilepsy or Generalized Seizures
i) ☐ Hepatitis B or C
j) ☐ Cirrhosis of the liver

3. In the past ten years, or as indicated below, have you been treated for, or been diagnosed with by a member of the medical profession as having any of the following conditions? **If yes, please check the box and provide details in Section 9.**

k) ☐ Non-Insulin Dependent/ Type II Diabetes
l) ☐ Mental & Nervous Disorder; Depression/Anxiety
m) ☐ Brain or Central Nervous System disorder; Parkinsonism, Absence Seizures/Petit Mal Epilepsy
n) ☐ Liver Disorder
o) ☐ Kidney Disorder
p) ☐ Blood Disorder
q) ☐ Stomach, Abdominal, Intestinal Disorder
r) ☐ Bone, Joint, Connective Tissue Disorder
s) ☐ Cancer, Tumors
t) ☐ Gland Disorder
u) ☐ Lungs, Respiratory Disorder

4. Have you consulted, been advised or been examined by any healthcare provider for any other medical reason within the last ten years, or as indicated above? ☐ Yes ☐ No
   If yes, please indicate condition and provide details in the Health Information Section.

Section 9: Spouse/Domestic Partner/Civil Union Partner Health Information *(to be completed by the applicable person)*

Question # or Letter	Details of Yes answers	Onset Mo.	Onset Yr.	Duration	Degree of recovery	Name/address/phone of attending physician

Please list all your medications

Medication	Dosage/Frequency	What condition is treated with this medication?	Onset Mo.	Onset Yr.

By signing below, I agree that all statements and answers recorded on this Application are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Signature of Spouse/Domestic Partner (if applicable)	Date

Print name

Remember to complete an "Authorization for Release of Medical Information" form to send to Symetra with this package.

Applicant's copy

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1. The agent may retain a copy of your application. If reinsurance is required, the reinsurance company would have access to our application file.
2. We may release information to another life insurance company to whom you have applied for life or health insurance or to whom you have submitted a claim for benefits, if you have authorized them to obtain this information.
3. We would disclose information to government regulatory officials, law enforcement authorities and others where required by law.

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If an adverse underwriting decision is made, we will notify you of the reason(s) for that decision and the source of the information upon which our action is based. Medical record information, however, will be given only to a licensed physician of your choice.*

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Symetra Life Insurance Company
PO Box 34690 | Seattle, WA 98124-1690
Phone: 1-800-426-7784 | Fax: 1-866-348-0058 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY
Authorization for Release of Medical Information

Group Life Policy Number: 01-018070-00

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____
Signature of Insured/Patient or Personal Representative Date

_____
Description of Personal Representative's Authority or Relationship to Patient

SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
PO Box 34690 | Seattle, WA 98124-1690
Phone: 1-800-426-7784 | Fax: 1-866-348-0058 | TTY/TDD 1-800-833-6388

Note: We will accept an authorization form preferred by your provider's office in place of this authorization form.

SYMETRA LIFE INSURANCE COMPANY
Authorization for Release of Medical Information

Group Life Policy Number: _____

Name of insured/patient (please type or print): _____ Date of birth: _____

I authorize any physician, health care professional, hospital, clinic, medical facility, laboratory, pharmacy or pharmacy benefit manager, other health care provider, insurance company, or government agency that has provided treatment, services, or payment to me or on my behalf ("My Providers") to disclose my entire medical record, medications prescribed, prescription history, and any other protected health information concerning me to Symetra Life Insurance Company, its employees, agents, or representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness, excluding psychotherapy notes, and the use of alcohol, drugs, and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Symetra Life Insurance Company may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; 3) obtain reinsurance; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Symetra Life Insurance Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Symetra Life Insurance Company. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this Authorization to disclose information about me or to the extent that Symetra Life Insurance Company has a legal right to contest a claim under an insurance policy. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Symetra Life Insurance Company except as authorized by me or as required by law.

This Authorization complies with the requirements of the Health Insurance Portability and Accountability Act (HIPAA).

I understand that if I refuse to sign this authorization to release my complete medical record, Symetra Life Insurance Company may not be able to process my application, continue my coverage, or make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_____ _____

Signature of Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient