CONFIDENTIAL INFORMATION RELEASE FORM INSTRUCTIONS

Life Insurance / Annuity Products

MAILING ADDRESS
11825 N. Pennsylvania St.
Carmel, IN 46032

FAX NUMBER: (800) 757-6324

INSTRUCTIONS TO COMPLETE FORM

This form is only valid for Life Insurance and Annuity products. Please read these instructions carefully before completing this form. Fill out all sections of the document and include appropriate signatures. If you would like to provide authorization on multiple policies, separate forms are needed for each policy number.

A. MY INFORMATION

1. This section is regarding the individual, "you", who is the subject of the information to be released. Complete all fields in this section with your information.
2. Check the box that identifies your relationship to the policy.

B. RECEIVING PARTY

1. The Receiving Party is the individual or organization that is being authorized to receive information about you. Provide the person/organization's information in this section.
2. Indicate what information may be released by checking one or more of the boxes. If the "Other" box is marked, list the specific information that may be disclosed.
3. The Receiving Party is only entitled to receive information. Changes to the policy cannot be made by the Receiving Party.

C. DURATION OF AUTHORIZATION

If you would like the authorization timeframe to be less than twelve (12) months, complete this section with the requested expiration date.

D. AUTHORIZATION / SIGNATURES

1. This section must be signed and dated by you or your legal representative. The authorization is not valid until these fields are completed.
2. If you are a legal representative, a copy of the legal authority documentation must be submitted with this form. Documentation includes, but is not limited to: Power of Attorney or Guardianship documents and Estate Paperwork (if the subject of the information is deceased).

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Please print clearly in ink. Refer to Instructions for information on how to complete each section.

Policy Number	Insured
Date	Owner (if other than Insured)

A MY INFORMATION

Name (Print full name)	Date of Birth	SSN/TIN	Telephone ( )
Address	City	State	Zip Code

Relationship to this policy :

☐ Beneficiary ☐ Insured / Annuitant ☐ Owner / Joint Owner

B RECEIVING PARTY

Name (Print full name)	Date of Birth	Last 4 Digits of SSN	Telephone ( )
Address	City	State	Zip Code

Information that may be released:

☐ Any/all information that could be disclosed to me may be disclosed to the Receiving Party, including health and financial information.

☐ Only the following information may be disclosed to the Receiving Party:

☐ Claim Information ☐ Policy Status ☐ Premium Information ☐ Other (describe information in detail)

_____

C DURATION OF AUTHORIZATION

Twelve (12) months from the date signed below, unless an earlier expiration date is specified here: _____

D AUTHORIZATION / SIGNATURES

I authorize CNO Services, LLC (on behalf of one or more of the following insurance companies: Bankers Life and Casualty Company, Bankers Conseco Life Insurance Company * *[*domiciled in and licensed in the State of New York*], Colonial Penn Life Insurance Company, Wilco Life Insurance Company, Conseco Life Insurance Company of Texas, Jefferson National Life Insurance Company, Washington National Insurance Company) to disclose information about me to the Receiving Party listed above.

I understand that I or my legal representative are entitled to a copy of this authorization and a photocopy or facsimile is as valid as the original.

Signature	Date
Printed Name	Relationship (if signed by Legal Representative **)

***Legal Representatives must provide documentation of legal authority*