ARGUS
Our Interest is You.

Group/Individual Health Authorisation Form

To:

Bermuda Life Insurance Company Limited (the "Company")

Authorisation:

I hereby authorise the Company and its affiliates, employees and agents to USE AND DISCLOSE my protected personal health information maintained by the Company (e.g., information relating to the diagnosis, treatment, records, examinations, claims payment and health care services provided or to be provided to me and which identifies my name, address, and or Member ID number) for the purpose of evaluating and administering my claims for health benefits or for evaluating my ongoing eligibility for health insurance coverage, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim forms to the third party listed below.

Insured Person's Name	Certificate Number	Third Party's Name	Relationship to Insured

Personal Health Information:

Personal Health Information includes my entire medical record, prescription drug history and insurance claim history, including HIV, AIDS or other disorders of the immune system, use of drugs or alcohol, mental or physical history, condition, advice or treatment.

Benefits:

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this Authorisation. I acknowledge that if I do not sign this Authorisation, or if I later alter or revoke it, the Company may not be able to effectively evaluate my claims or eligibility for health insurance.

Revocation:

I understand that I have the right to revoke this Authorisation, in writing, at any time. I understand that any action already taken in reliance on this Authorisation cannot be reversed, and my revocation will not affect those actions.

Termination:

This Authorisation shall be in force and effective for the entire period of health insurance coverage under the above noted Certificate Number from the date of my signature below (or my authorised representative) until, revocation in writing by myself (or my authorised representative), until my health benefit coverage ceases under the Certificate Number identified above or, if applicable, the duration of any outstanding or unresolved claims submitted on my behalf, at which time this authorisation shall expire.

Waiver:

By signing this document, I hereby agree to hold the Company, and its affiliates, heirs and successors however so named, as well as their officers, directors and employees harmless and waive them, their officers, directors and employees, from any possible liability, losses, fines, penalties or expenses (including defense costs such as reasonable attorney fees and expenses) they may incur arising solely as a result of any actions undertaken by them in accordance with this Authorisation and the terms of the Group/Individual Health Plan.

Signature Date (MM/DD/YY)

Printed name of individual subject to this disclosure Date (MM/DD/YY)

If applicable, I signed on behalf of the insured as _____ (indicate relationship).
If Legal Guardian or Power of Attorney designee, please attach a copy of the document granting authority.

Printed Name of Legal Representative Signature of Legal Representative Date Signed (MM/DD/YYYY)