Farm Bureau Life Insurance Company
5400 University Avenue
West Des Moines, Iowa
50266-5997

FARM BUREAU FINANCIAL SERVICES

AUTHORIZATION

This form is used to authorize Farm Bureau Life Insurance Company to release health and/or underwriting information to the applicant's Agent or a company for the purpose of completing the application for insurance and underwriting process.

Name of Applicant: _____ Date of Birth: _____

USE OR DISCLOSURE BEING AUTHORIZED

Entity Authorized to Disclose: Farm Bureau Life Insurance Company ("Farm Bureau")

Entity Authorized to Receive:

Name of Agent: Nick Elbert Company Name: OCI

Protected Health and/or Underwriting Information to be Disclosed and Purpose: Farm Bureau may disclose information concerning any past, present and future health care treatment or conditions as needed to complete the application for insurance or underwriting process.

No Conditions: This authorization is voluntary. Farm Bureau will not condition your application for life insurance or an annuity, eligibility for coverage or payment of claims on giving this authorization.

Prohibition on Redisclosure and Effect of Granting this Authorization: This form does not authorize the disclosure of medical information beyond the limits of the authorization. Where information has been disclosed from the records protected by Federal law for alcohol/drug abuse records or state law for mental health records, the Federal requirements (42 CFR Part 2) and applicable state requirements prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. I understand that if the entity that receives the information requested is not covered by Federal or state privacy laws, the information described above may be redisclosed and will no longer be protected by law.

EXPIRATION AND REVOCATION

Expiration: This authorization is in force until 60 days after the underwriting decision has been made.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Farm Bureau at the address stated above. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before Farm Bureau received my written notice of revocation.

INDIVIDUAL'S SIGNATURE

Specific Authorization for Release of Mental Health, Substance Abuse Treatment or AIDS-Related Information: I authorize the release and disclosure of any and all personal health information, including specifically mental health information, substance abuse (drug or alcohol), and AIDS-related information, if applicable, and all claims information to the individual or entity named above as long as this authorization is in effect. I understand that I may inspect the mental health information disclosed.

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my health and/or underwriting information, as described in this form. If this authorization involves the disclosure of mental health information, I acknowledge receipt of a copy of the authorization.

Signature: _____ **Date**: _____

A parent of an individual 18 years or older or a spouse may NOT sign on behalf of the individual.

Retain a copy for your records.