

The Ohio National Life Insurance Company

Ohio National Life Assurance Corporation

Please detach
and deliver to
proposed insured
immediately.

P.O. Box 237
Cincinnati, Ohio 45201-0237
(513) 794-6100

Notice of Information Practices

One of the prime objectives of Ohio National is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure low cost, but also to assure that the fair share of the cost is contributed by each policyholder. Information from a number of sources is considered when we evaluate your application. We consider the results of your physical examination, if required, and any reports Ohio National may receive from doctors and hospitals who have attended you.

Information regarding your insurability and claims will be treated as confidential. Ohio National or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, upon request, will supply such company with the information it may have in its file.

The purpose of the MIB is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by the MIB may alert the insurer to the possible need for further investigation. The MIB is not a repository of medical reports from hospitals and physicians, and information in the MIB file does not reveal whether applications for insurance are accepted, rated, or declined.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Telephone number (617) 426-3660.

When authorized by you, Ohio National or its reinsurers may also release information in its file to other life insurance companies to which you may apply for life or health insurance, or to which a claim for benefits may be submitted.

Furthermore, as part of the processing of your insurance application, we may request an investigative consumer report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to be personally interviewed if we order an investigative consumer report. Please notify our agent if this is your desire. You also have the right to receive a copy of the report and, by making a written request to Ohio National within a reasonable period of time, to receive additional, detailed information about the nature and scope of this investigation.

As a general practice, we will not disclose personal information about you to anyone else without your consent, unless a legitimate business need exists or disclosure is required or permitted by law. You are entitled, upon request, to receive a more detailed statement of our information practices. You also have the right to ask about personal information which we may have in our files and the right to seek a correction of information you think is wrong.

Ask our agent for assistance, or write or call us at Ohio National, Attention: Underwriting Division, P.O. Box 237, Cincinnati, Ohio 45201-0237. Telephone (513) 794-6100.

Thank you for your application.

Authorization For Release Of Personal Health Information

This authorization is designed to comply with the HIPAA Privacy Rule.

I hereby authorize any health plan, health care provider or health care clearinghouse that has provided payment, treatment or services to the Patient or on his or her behalf to release to the persons or entities identified in Paragraph Number 1 information it has about the Patient's physical or mental health. Paragraph Number 2 describes the class of persons or entities hereby authorized to release personal health information about the Patient. These persons or entities may disclose the information described in paragraph Number 3.

Proposed Insured
Patient's Name: _____
Date of Birth: _____ SSN: _____

Additional Insured
Patient's Name: _____
Date of Birth: _____ SSN: _____

1. The records and information will be disclosed to **The Ohio National Life Insurance Company or Ohio National Life Assurance Corporation**, (Ohio National) P.O. Box 237, Cincinnati, Ohio 45201 and their contractors, employees, representatives, affiliates and assigns as necessary to fulfill the purpose of this disclosure.
2. **Persons or entities hereby authorized to disclose personal health information about the Patient:** Any health plan, physician, surgeon, health care professional, hospital, clinic, laboratory, pharmacy, pharmacist, pharmacy benefit manager, medical facility or medically related facility, insurance company, reinsurance company, insurance support organization (such as the Medical Information Bureau, Inc. [MIB]) or other health care provider, the Veterans Administration; a consumer reporting agency and employer.
3. **Description of the information that may be disclosed:** This authorization specifically includes the release of the Patient's **entire medical record** and any other protected health information concerning the Patient including, without limitation, office notes, including those that describe a diagnosis, prognosis or response to treatment; results of all diagnostic tests; surgical notes; notes describing treatments provided, prescribed or recommended; history of prescriptions for pharmaceuticals; and all other information in your custody or control about any medical care or treatment provided to the Patient. This authorization specifically includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV), sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco. You may also disclose any financial, employment or personal information requested for insurance purposes.

The purpose of this disclosure is to evaluate an application for insurance or claim for benefits.

Ohio National may re-disclose information to reinsurance companies, to MIB, or their representatives, or to others who perform business or legal services related to the application or the policy or claim thereunder; in which case it may not be protected under federal privacy rules. Information will not be released to anyone else unless required or permitted by law or unless further authorized.

- This authorization is good, as needed, for 26 months from the date signed or while a claim is open, if longer.
- I agree that a photocopy or facsimile of this authorization may be used the same as the original.
- I have received Ohio National's Notice of Information Practices.
- I acknowledge that I have read this Authorization and received a copy of it.
- I understand that I may revoke this Authorization by sending written notice to Ohio National. Actions taken in reliance of this Authorization will not be affected, but no further actions will be taken in reliance of this Authorization after revocation is received by Ohio National. Revocation of this Authorization may result in the refusal to offer insurance coverage or pay benefits under a policy that has been issued.

_____ Signature of Patient/Proposed Insured
_____ Date
If signed on behalf of Patient/Proposed Insured, the signer is the Patient's:
____ Parent/Guardian of minor
____ Other (specify) _____

_____ Signature of Patient/Proposed Additional Insured
_____ Date
If signed on behalf of Patient/ Proposed Additional Insured, the signer is the Patient's:
____ Parent/Guardian of minor
____ Other (specify) _____

Leave this copy with proposed insured

Authorization For Release Of Personal Health Information

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Proposed Insured
Patient's Name: _____
Date of Birth: _____ SSN: _____

Additional Insured
Patient's Name: _____
Date of Birth: _____ SSN: _____

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_____ Signature of Patient/Proposed Insured
_____ Date
If signed on behalf of Patient/Proposed Insured, the signer is the Patient's:
____ Parent/Guardian of minor
____ Other (specify) _____

_____ Signature of Patient/Proposed Additional Insured
_____ Date
If signed on behalf of Patient/ Proposed Additional Insured, the signer is the Patient's:
____ Parent/Guardian of minor
____ Other (specify) _____

Return this copy to the Home Office