WORLD INSURANCE

P. O. Box 3160 • Omaha, NE 68103-0160 • (402) 496-8000 • FAX: (402) 496-8040

Authorization for the Use and Disclosure of Information

I hereby authorize the use and/or disclose of my information as described below. **I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.**

Insured whose information is being requested for use/disclosure: _____

1. Persons/class of persons authorized to use or make disclosure of the information: _____
   Legal and Compliance Services Staff
2. Name and address of persons/class of persons authorized to receive the information:
   RECORDS DEPOSITION SERVICE, INC.
   PO BOX 5054 P: 248.357.3330
   SOUTHFIELD, MI 48086-5054 F: 248.357.3337
   Specific description of information that may be used/disclosed: _____
3. The information will be used/disclosed for the following purposes (*all* purposes must be listed and described):
   Purpose 1 FOR DISCOVERY BEFORE TRIAL
   Purpose 2
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, World Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that World Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.
5. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
   (a) [World Insurance Company] or another third party has taken action in reliance on this authorization; or
   (b) If this authorization is obtained as a condition for obtaining insurance coverage, other law may provide [World Insurance Company] with the right to contest a claim under the policy or the policy itself.

   I understand to revoke my authorization I should send my written revocation request to: [World Insurance Company], Customer Service Center, P.O. Box 3160, Omaha, NE, 68103-0160. I further understand as a consequence of my revocation of this authorization, World Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that World Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.
6. This Authorization will expire 24 months from the date of signature.

If you are signing as a personal representative for the policy/certificate holder, please read and sign below.

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____, that my relationship to the policy/certificate holder is

_____, and that I have the lawful authority to enter into this authorization on behalf of the policy/certificate holder. I have read the provisions set forth in this authorization, and agree that [World Insurance Company] may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____

Signature of Individual or Personal Representative

Date

_____ _____

Printed Name of Individual or Personal Representative

Relationship of Personal Representative or authority to act For the Individual

YOU WILL BE PROVIDED WITH A COPY OF THIS SIGNED AUTHORIZATION