



Nippon Life Insurance Company
of America
PO Box 10310
Des Moines, IA 50306-0310

*Authorization for Release
of Health Information for
Underwriting Purposes –
All States*

I authorize that any/all health statements that I have signed within the 90-day period prior to the date this form is signed can be released to Nippon Life Insurance Company of America (NLB) for the purpose of underwriting the group insurance benefits provided by the employer named below.

I understand that if I refuse to provide this authorization, NLB may not make an underwriting determination, and I will not be considered for coverage with NLB.

I represent to NLB that information, statements, and answers on my health statements, and any attachments, are complete and true to the best of my knowledge and belief. They are part of this request for coverage under the NLB group policies. I agree NLB is not liable for claims that happen or begin before the effective date of coverage by NLB.

I have read, or had read to me, the questions and responses on my health statements and realize that any false statements, omissions or material misrepresentation regarding age or health information could cause coverages, if issued, to be cancelled as never effective.

I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give NLB, its underwriters along with its agents and employees performing business transactions, any such data.

I have read and I understand this authorization.

Name of employee

Date of birth

Employer name

Signature of employee

Date