Re: Certificate No. ________________________
Insured Member: ______________________

Dear.

This letter authorizes a person/persons not covered under the above referenced Certificate/Policy to make coverage changes as well as obtain information concerning this coverage. This does not include canceling insurance coverage. The following must be signed by you and returned to our office.

AUTHORIZATION TO MAKE COVERAGE CHANGES

I, ____________________________________, am exercising my right under the HIPAA Privacy Regulations effective 4-15-03, to name my __________________ (Relationship), _____________________________ (Name), as my Individual Personal Representative. By naming him/her as such, I _____________________ am authorizing Mid-West National Life Insurance Company of Tennessee in North Richland Hills, Texas, to release benefit information, claim status, payment or denial information and further authorize _______________________ to make changes to coverage.

The information may be released/changed on the following person/persons covered under my Certificate/Policy:

____
____

Please maintain this letter in my records. This authorization will remain in effect unless notified by me in writing.

____________________________   _____________________
Signature of Insured   Date

We appreciate your attention to this matter. If you have any questions, please contact our Customer Care Center at (800)733-1110, or you can fax your inquiry to (888)377-4391.

Sincerely,

Mid-West National Life Insurance Company
The Customer Care Center

J863/SLTR