

First **Catholic** Slovak Ladies **Association**

MIB Notice to the Proposed Insured

Information regarding your insurability will be treated as confidential. The First Catholic Slovak Ladies Association of the USA or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

First Catholic Slovak Ladies Association of the USA, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

(Please detach and return with application)

MIB Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, **MIB, Inc. ("MIB")** or other organization, institution or person, that has any records or knowledge of me or my health, to give to the First Catholic Slovak Ladies Association of the USA, or its reinsurers, any such information.

A photographic copy of this authorization shall be as valid as the original.

Signature of Proposed Insured (Parent or Guardian if Proposed Insured is under age 16)

Date

By signing below, I agree that I have received a copy of the MIB Notice to the Proposed Insured.

Signature of Proposed Insured (Parent or Guardian if Proposed Insured is under age 16)

Date