Authorization for Disclosure of Personal Information for Joint Insureds and Contingent Owners Only
(Non-medical Information)

Products and financial services provided by
The State Life Insurance Company
a ONEAMERICA® *company*
P.O. Box 406
Indianapolis, IN 46206
1-800-275-5101

ONEAMERICA®

Policy Owner(s): _____ Insured(s)/Annuitant(s): _____

I, _____ , Policy No. _____ ,
(please print policy owner's name)

hereby authorize The State Life Insurance Company, hereinafter referred to as "the Company", to disclose my non-medical information, including financial information, as described below for the purposes of policy administration and processing my claim for benefits at my request.

Person Authorized to Receive Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Me: _____ Date of Birth: (for identity verification purposes) _____

Your Signature:

_____ _____
Policy Owner or Legal Representative Date

_____ _____
Daytime Phone Number of Policy Owner or Legal Representative State in which this authorization was signed

Description of Representative's Authority: _____
(as Guardian, Person with Power of Attorney, etc.)

A photocopy of this authorization is as valid as the original.

Send this form to: OneAmerica companies, P.O. Box 368, Indianapolis, Indiana 46206-0308 for policy administration purposes.
OneAmerica companies, P.O. Box 6122, Indianapolis, Indiana 46206-6122 for claims purposes.

YOUR RIGHTS

- I understand that I may revoke this authorization at any time by notifying in writing the Privacy Manager at OneAmerica Financial Partners, Inc., One American Square, P.O. Box 368, Indianapolis, Indiana 46206, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the non-medical information that the Company took before it received the revocation.
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving person and may no longer be protected by the federal and state privacy laws.
- By signing this form, I agree to the disclosure of my non-medical information to the person listed above and I relieve the OneAmerica companies from all liability having to do with that disclosure.
- I am entitled to a copy of this authorization form.