

AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

As part of my use of Medicare Suggest (the "Service"), I understand and agree that I may direct Milliman, Inc. ("Milliman") to retrieve my protected health information described below and maintained by covered entities and other third parties ("My Information"). Each such covered entity and other third party from which I direct Milliman to retrieve My Information as part of my use of the Service shall be referred to as an "Information Controller."

1. Authorization

I hereby authorize each Information Controller to disclose My Information described below to Milliman, Inc. ("Milliman"). I also hereby authorize Milliman, as my agent and attorney-in-fact, to obtain My Information from each Information Controller. Milliman may use and store My Information in accordance with this Authorization, the Service's Terms of Use, and the Service's Privacy Policy.

2. Effective Period

This authorization for release of information covers My Information from all past, present, and future periods.

3. Extent of Authorization

I hereby authorize the release of My Information, which includes but is not limited to, my complete health records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse ("My Information"). I understand that I do not have the option to select which portions of My Information are released. Therefore, **if I do not authorize the release of My Information, I understand and agree that I cannot proceed to use the Service.**

4. My Information may be used by Milliman as part of The Service, including using My Information for calibration and improvement of the Service.

5. This authorization shall be in force and effect until the earlier of (1) it is revoked by me pursuant to Section 6 below or (2) when I close my account, at which time this authorization expires. **I understand and agree that, to close my account, I can click "Delete Account" button in my account profile.**

6. I understand that I have the right to revoke this authorization at any time by either (1) submitting a written revocation to Milliman, Inc., Attn: Legal Department, 1301 Fifth Avenue, Suite 3800 Seattle, WA 98101 USA or (2) closing my account. If I revoke this authorization, My Information will no longer be used or disclosed for the reasons stated in this authorization. However, I understand my revocation will not apply to information already retained, used, or disclosed prior to such revocation.

7. I understand that Milliman will not be providing me with any treatment, payment, enrollment, or eligibility for benefits and, as such, the foregoing will not be conditioned on whether I sign this authorization.

8. I understand a copy of this authorization is available to me, upon request, and will serve as the original.

9. Milliman will not disclose your information to third parties, except as authorized by you, as required to provide the Services, or as required by law. However, I understand that, if I authorize the disclosure of My Information, it is possible that the recipient may further disclose My Information to others and, as a result of such disclosure, may no longer be protected to the same extent the My Information was protected by law while solely in the possession of Milliman.