

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	This form is HIPAA compliant
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Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, LIFE Brokerage, LLC, brokers, contractors, employees, representatives and agents working through LIFE Brokerage, LLC for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Abacus Settlements, LLC	Fasano Associates, Inc.	Lincoln National Life Insurance Co	Prudential Life Ins. Co. / Pruco Life
Advantage Insurance Network, Inc.	Fidelity & Guaranty Life Ins Co	Lloyd's of London	RSA Medical
Allianz	First Global Financial & Insurance	Massachusetts Mutual	SBLI
American General Life (AIG)	First Insurance Funding	Minnesota Life / Securian	Security Mutual
AmericanNational	First Penn	Mutual of Omaha	Standard Life
Americo	Foresters	National Life of Vermont	Sun Life Ins. Co. of America
Assurity Life	General American Life Ins. Co.	National Western	Sun Life Ins. Co. of Canada
Accordia/Global Atlantic	Global Insurance Underwriters	Nationwide Life & Annuity Co.	Superior Medical Group
Ameritas	GE Financial Assurance Co.	New Investor World, Inc.	Symetra
Ashar	Genworth Life Insurance Co.	New York Life Insurance Co.	Transamerica Life Insurance Co.
AVS, LLC	Genworth Life and Annuity	North American Co.	Travelers Life & Annuity
AUS Underwriting	Guardian Life Ins. Co.	Old Mutual Financial Network	21st Services
AXA / MONY / AXA Equitable	Hartford Life Insurance Co.	One America	Union Central Life
Banner Life	Industrial Alliance Pacific	Pacific Life	United of Omaha
Beneficial Financial Group	IBU, Inc.	Penn Mutual	USG Annuity & Life
Bragg Associates	ISC Services	Petersen International Underwriters	Voya - ReliaStar Life of New York
Brighthouse Financial	John Hancock Life Ins. Co.	Premium Funding Group (PFG)	Voya - ReliaStar Life Insurance Company
LIFE Brokerage, LLC	John Hancock USA	Pioneer Mutual	Voya - Security Connecticut Life
Columbus Life	Lafayette Life	Phoenix Life	Voya - Security Life of Denver
Concord Capital/INSCAP	Lewis and Ellis, Inc.	Presidential Life	West Coast Life Insurance Co.
Coventry First, LLC	Life Insurance of the Southwest	Principal Life Insurance Company	Western Reserve Life
Equity Key, LLC	LifeShare	Principal National Life Insurance Company	William Penn Life Ins. Co.
Equity Release	Lincoln Benefit Life	Professional Underwriting Services	Zurich American Life Insurance Company
Examination Management Services, Inc.	Lincoln Financial/ Lincoln Life	Protective Life Ins Co.	

Additional Insurers and Agencies:

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment; (3) pharmacy prescriptions; (4) HIV testing and treatment, except where prohibited by law; (5) sexually transmitted diseases; (6) Sickle Cell testing and treatment; (7) laboratory test results; (8) other insurance coverage; (9) hazardous activities; (10) character; (11) general reputation; (12) mode of living; (13) finances; (14) occupation; and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to LIFE Brokerage, LLC, the Insurers and Agencies listed afore and to:

Agent/Producer Name: _____

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

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NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation; personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.

MEDICAL INFORMATION

Please include the name, address, and telephone number of each physician listed.

Personal Primary Care Physician: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
List any Clinics or Hospitals Name: Address:	Telephone Number:	Date of Admission:	Reason for Admission:

List all current medications:_____

Non Medical Questions

P11 1. Height (in shoes) 2. Weight (clothed) Weight change in last year? ☐ Yes ☐ No
 _____ft. _____in. _____lbs. If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

P12 3. Height (in shoes) 4. Weight (clothed) Weight change in last year? ☐ Yes ☐ No
 _____ft. _____in. _____lbs. If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

	P11	P12	P11	P12
5. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter?	☐ Yes	☐ No	☐ Yes	☐ No
6. During the past 10 years, has a licensed member of the medical profession treated you for, or made a diagnosis of:	☐	☐	☐	☐
a. High blood pressure, chest discomfort, heart attack, heart murmur, circulatory or heart disorder?	Yes	No	Yes	No
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?	☐	☐	☐	☐
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?	Yes	No	Yes	No
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?	☐	☐	☐	☐
e. Anemia, leukemia or other blood or clotting disorder?	Yes	No	Yes	No
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?	☐	☐	☐	☐
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?	Yes	No	Yes	No
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?	☐	☐	☐	☐
i. Cancer, tumor, polyp or cyst?	Yes	No	Yes	No
j. Disorder of eyes, ears, nose or throat?	☐	☐	☐	☐
k. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?	Yes	No	Yes	No
Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system or a positive blood test for antibodies to the HIV virus?	Yes	No	Yes	No
	☐	☐	☐	☐
7. Have you ever used any controlled substances such as: amphetamines, barbiturates, hallucinogens, heroin, morphine, cocaine, marijuana, opiates or any prescription drug, except as prescribed by a physician?	Yes	No	Yes	No
If yes, please complete Substance Use Questionnaire PM0293.	☐	☐	☐	☐
8. Have you ever been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use? If yes, please complete Substance Use Questionnaire PM0293.	Yes	No	Yes	No
	☐	☐	☐	☐
9. Other than previously stated, have you within the past 5 years:				
a. Consulted a physician or any other practitioner, had a check-up, illness, surgery or been hospitalized?	☐ Yes	☐ No	☐ Yes	☐ No
b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test, excluding HIV related tests?	☐ Yes	☐ No	☐ Yes	☐ No
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed, excluding HIV related tests?	Yes	No	Yes	No

Non-Medical Questions (Continued)

10. Family History (Complete amount of insurance only if Proposed Insured is under age 17)*

Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed or treated by a member of the medical profession as having diabetes, heart disease, TIA (transient ischemic attack) or other cerebrovascular disorder, cancer, stroke, Huntington's disease and Chorea, neuromuscular disorder, or kidney disease prior to age 60?

PI 1 ☐ Yes ☐ No PI 2 ☐ Yes ☐ No (If Yes, provide details in Medical Impairment section below).

	Age(s) (if living)	Age(s) (at death)	Medical Impairment	Cause of Death	Amount of Insurance*
Father (PI 1)					
Father (PI 2)					
Mother (PI 1)					
Mother (PI 2)					
Brother (PI 1)					
Brother (PI 2)					
Sister (PI 1)					
Sister (PI 2)					

Details for Medical History Questions

[illegible]

Personal Information Page

Please complete this form in its entirety. Missing information may delay the establishment of your policy.

Personal Information

Name:	Sex: Male / Female
Date of Birth:	Social Security #
Birthplace:	Citizenship:
Home Address:	
Home Phone:	Work Phone:
Cell Phone:	Email:
Drivers License #	Drivers License State:
DL Issue Date:	DL Expiration Date:
Annual Earned Income:	Unearned Income Net Worth:
Liquid Assets:	Federal Income Tax Bracket:
Occupation:	Name of Employer:
Employer Address:	

Personal History Questions

1. Do you anticipate any foreign travel within the next 2 years? _____
2. Within the last 3 years have you been, or within the next 2 years do you expect to become a pilot? _____
☐ Yes ☐ No
3. Within the last 3 years have you taken part in, or within the next 2 years expect to take part in any hazardous activities or extreme sports (diving, hang gliding, para sailing, skydiving...)? _____
☐ Yes ☐ No
4. Within the last 5 years, have you been in a motor vehicle accident or convicted of a moving violation? _____
☐ Yes ☐ No
5. Within the last 10 years, have you been convicted of operating a motor vehicle while under the influence of alcohol or drugs? _____
☐ Yes ☐ No
6. Have you ever been convicted of a felony, or currently on parole or probation? _____
☐ Yes ☐ No

If you answered yes to any of the questions above, please provide explanation below.

☐ Yes ☐ No

Account Information

Primary Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Primary Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

In Force Life Insurance

Date Issued: Carrier: Type:

Insured: Face Amount: Policy #

Spouse:

Siblings (If Juvenile Insured):

Additional Requirements for Disability Insurance:

Employer Paid Benefits

Plan Design:

Benefit Amount: Benefit Period:

Elimination Period: Other Individual Coverage:

Number of Employees: Owner:

