AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: ____________________________________

THE COMPANIES:	
Advantage Insurance Network (AIN)	2801 Townsgate Road, Suite 350, Westlake Village, CA 91361
Allianz Life Insurance Company of North America	P.O. Box 59060, Minneapolis, MN 55459-0060
American National Insurance Company American National Life Ins. Co. of New York	One Moody Plaza, Galveston, Texas 77550-7947 344 Route 9W, Glenmont, NY 12077
Ameritas Life Insurance Company and Ameritas Life Insurance Corp. of New York	P.O. Box 81889, Lincoln, NE 68501
Banner Life Insurance Company	3275 Bennett Creek Ave., Frederick, MD 21704
Brighthouse Financial	1209 Orange St., Wilmington, DE 19801
Brighthouse Life Insurance Co. of NY	New York, NY 10017
Corebridge Financial Corebridge Financial (USL)	2727-A Allen Parkway, Houston, Texas 77019 28 Liberty St., 45th Floor, New York, NY 10005-1400
Equitable Financial Life Insurance Company and Equitable Financial Life Ins. Co. of America	P.O. Box 1047, Charlotte, NC 28201-1047
Fidelity & Guaranty Life	801 Grand Ave., Des Moines, IA 50309-8000
First Symetra National Life Insurance Company of NY	420 Lexington Avenue, Suite 300, New York, NY 10170-0399
Foresters	789 Don Mills Road, Toronto, Ontario M3C1T9
John Hancock Life Ins. Co. (U.S.A) and John Hancock Life Ins. Co. of New York	410 University Avenue, Suite 55765, Westwood, MA 02090
Lafayette Life Insurance Co. (non-NY only)	400 Broadway, Cincinnati, OH 45202-3341
Life Ins. Co. of Southwest (National Life Group)	One National Life Drive, Montpelier, VT 05604
Lincoln Financial Group, Lincoln National Life Insurance Company and Lincoln Life & Annuity Co. of New York	P.O. Box 21008, Greensboro, NC 27420-1008
Massachusetts Mutual Life Ins. Co. (MassMutual)	1295 State Street, Springfield, MA 01111-0001
Minnesota Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
Mutual of Omaha Insurance Co.	3330 Mutual of Omaha Plaza, Omaha, NE 68175
National Life of Vermont (National Life Group)	One National Life Drive, Montpelier, VT 05604
Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company	P.O. Box 182928, Columbus, OH 43218-2928
New York Life Insurance Company	1140 Tomahawk Creek Parkway, Ste. 200, Leawood, KS 66211
North American Company for Life & Health Insurance	P.O. Box 5088, Sioux Falls, SD 57117
OneAmerica – The State Life Insurance Company	One American Square, P.O. Box 368, Indianapolis, IN 46206-0368
Pacific Life Insurance Company and Pacific Life and Annuity Company	P.O. Box 2030, Omaha, NE 68103-2030
Pacific Life Insurance Company (Lynchburg)	P.O. Box 2869, Omaha, NE 68103
Principal Life Insurance Company and Principal National Life Insurance Company	P.O. Box 14455, Des Moines, IA 50306-3455
Protective Life Insurance Company and Protective Life and Annuity of New York	P.O. Box 830619, Birmingham, AL 35283-0619
Prudential Insurance Company of America, Pruco Life Insurance Co. (except in NY), and Pruco Life Insurance Co. of New Jersey (in NY and NJ)	Attn: Underwriting, 13001 County Road 10, 4th Floor, Plymouth, MN 55442
Securian Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
Symetra Life Insurance Company	777 108th Ave NE, Suite 1200, Bellevue, WA 98004-5135
Transamerica Financial Life Insurance Company Transamerica Life Insurance Company	440 Mamaroneck Avenue, Harrison, NY 10528 6400 C Street SW, Cedar Rapids, IA 52499
United of Omaha Life Insurance Company	3330 Mutual of Omaha Plaza, Omaha, NE 68131
William Penn Insurance Company of New York	3275 Bennett Creek Ave., Frederick, MD 21704

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (continued)

The terms that follow have the respective meanings when used in this Authorization:

INSURANCE SUPPORT ORGANIZATIONS:	Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU:	Medical Information Bureau, Inc.
AUTHORIZATION:	Authorization to Obtain and Disclose Information

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits;

Signed at ______________________________ this ______________ day of __________________ 20_____

_______________________________________ _______________________________________

Proposed Insured Signature Proposed Owner's Signature

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

_______________________________________ _______________________________________

Name of Minor Child Signature of Minor Child's Authorized Representative

_______________________________________ _______________________________________

Name of Minor Child's Authorized Representative Witness (Broker)

Authorization for Release of Health-Related Information - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
______________________	______________________
______________________	______________________
______________________	______________________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured, Patient, or Personal Representative Date
x

Signature of Proposed Insured, Patient, or Personal Representative Date
x

Signature of Proposed Insured, Patient, or Personal Representative Date
x

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Personal Psychotherapy Notes - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization | Date of Birth

_______________________________ | _______________

_______________________________ | _______________

_______________________________ | _______________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record as described above without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record as described above, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Description of Personal Representative's Authority or Relationship to Patient

x ____