

Name of Proposed Insured/Patient \_\_\_\_\_

Date of Birth \_\_\_\_\_ S S Number \_\_\_\_\_

I authorize the companies listed below, their affiliates, re-insurers, insurance support organizations, and their representatives to obtain medical and other information in order to evaluate this application for insurance.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider, that has information available or has provided medical care, treatment, advice or services to me or on my behalf within the past 10 years (My Providers) to disclose such information, including my entire medical record and any other protected health information concerning me to the companies listed below, their agents, employees and representatives.

This includes information on the diagnosis and 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.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that the companies listed below may underwrite my application for coverage.

This authorization shall remain in force for 30 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.

I understand that my providers may not refuse to provide treatment 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 records the companies listed below may not be able to process my application.

AIG	ING
AETNA	LINCOLN BENEFIT
AMERICAN GENERAL	LINCOLN LIFE
AMERICAN NATIONAL	LINCOLN NATIONAL
BANKERS LIFE OF NY	MASS MUTUAL
BANNER LIFE	MET LIFE
CHASE LIFE INSURANCE	OLD LINE
COLUMBIAN MUTUAL	PRINCIPAL
COMPANION LIFE	PROTECTIVE LIFE AND ANNUITY
CONNECTICUT NATIONAL	PRUDENTIAL
EMPIRE GENERAL	RELIASTAR
FIRST COLONY	SECURITY CONNECTICUT
F & G	SECURITY MUTUAL
FARMERS & TRADERS	STATE LIFE
GENWORTH	SUN LIFE
GENERAL AMERICAN	TRANSAMERICA
GUARANTEE TRUST	US FINANCIAL
GUARDIAN	US LIFE
JEFFERSON PILOT	UNION CENTRAL
JOHN HANCOCK	UNITED OF OMAHA
INDIANAPOLIS LIFE	WILLIAM PENN

Date \_\_\_\_\_ Signature \_\_\_\_\_