Authorization for Release of Information

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 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: _____

Date of Birth_____ Social Security Number _____

Authorized Recipients
Insurance Companies and Agencies

Accordia Life	Gleaner Life Insurance Society	Penn Mutual
AGLA	Global Atlantic/Forethought Life	Principal
Allianz	Integrity Life	Prosperity Life
American Equity	Jetstream	Protective Life
American National	John Hancock	Prudential
Americo	Knighthead Annuity	Reliance Standard
Ameritas	International	Royal Neighbors
Annexus	Lafayette Life	Sagicor
ASPIDA	Legacy Marketing	SBLI
Assurity	Liberty Bankers Life	Securian
Athene	Lincoln Financial Group	Security Benefit
Athene National	Lloyds of London	Sentinel Security Life
Atlantic Coast Life	LSW/National Life Group	SILAC
AXA Equitable Life	Mass Mutual	The Standard
Banner Life (Legal & Gen)	Mass Mutual Ascend	Symetra
Clearspring Life and Annuity	(formerly Great American)	Transamerica
Co. (formerly Guggenheim Life)	Met Life	Upstream
Columbus Life	Mutual of Omaha	US Life
Corebridge	Mutual Trust Life	Venerable (Formally VOYA)
Delaware Life	Nassau RE	W&S Financial Group
Equitrust	National Guardian Life	William Penn Life
ExamOne	National Western Life	(Legal & Gen.)
F&G Life	Nationwide	Other:_____
Foresters	New York Life	Other:_____
Genworth	North American	
Gerber Life	Oceanview	
Guaranty Income Life	OneAmerica	
Insurance Co., a Kuvare Co.	Oxford Life	
(GILICO)	Pacific Life	

Signed at _____ this _____day of _____20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

Date of Birth_____ Social Security Number _____