



AGENT SUPPORT GROUP

Authorization for Release of Health-Related Information to Agent Support Group and subsidiaries This Authorization complies with the HIPAA Privacy Rules

Insured/Patient _____ Date of Birth _____ S.S.# _____

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize (Agent Support Group) (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g. a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured's Signature

Signed and Dated On

At (City, State, Zip Code)

Agent / Witness Signature: _____

Print Agent / Witness Name: _____

Companies to which this authorization applies to,

- | | | | |
|----------------------|-------------------------|--------------------------------------|---|
| 21st Century | Genworth Financial | Metropolitan Life | RSA Medical |
| Advanced Settlements | Genworth Life & Annuity | Minnesota Life | SBLI |
| Allianz Life | General American | Mutual of Omaha | Scan Tech Solutions |
| Allstate Life of NY | Goldman Sachs & Co | National Integrity | Securian |
| American General | Guardian | Nationwide | Security Mutual |
| American National | Hartford Life | New York Life | Sun Life |
| ANICO | Hooper Holmes | Northwestern Mutual | Symetra |
| AVIVA | Indianapolis Life | Pacific Life | Transamerica Life Insurance Co. |
| AVS | Integrity Life | Pan American Life Insurance Group | Transamerica Financial Life Insurance Co |
| AXA- Equitable | John Hancock | Parameds.com | Union Central |
| Bankers Life | Life Settlements | Penn Mutual | Universal Life Insurance Group. |
| Banner Life | Lifestyle Settlements | Phoenix Life | Universal Underwriters Life Insurance Co. |
| Berkshire Life & DI | Lifemark Partners | Portamedic | UNUM |
| Companion Life of NY | Lincoln Benefit Life | Premium Funding Group | US Financial |
| Coventry First | Lincoln Life & Annuity | Presidential Life | US Life |
| Credit Suisse | Lincoln Financial Group | Principal Life Insurance Co. | USG Annuity |
| Eastport Capital | Manulife Bermuda | Principal National Life Insurance Co | Welcome Funds |
| EMS | Mass Mutual | Protective Life | West Coast Life |
| Exam One | MedAmerican | Prudential Financial | William Penn |
| First Penn | Medconnect | ReliaStar ING | Zurich American Life Insurance Co |

Additional Insurance Carrier(s): _____ Insured Initials: _____