

Trial Application and HIPAA Authorization

Section A - Proposed Insured

1. First, Middle, Last Name:		2. <input type="checkbox"/> Male <input type="checkbox"/> Female	3. Date of Birth:
4. SSN: fix boxes	5. Drivers License #:		6. State:
7. US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Perm. Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Visa Type: Country of Citizenship:			
8. Address:			9. City:
10. State:	11. Zip:	12. Occupation:	
13. Income:		14. Total Assets:	
15. Total Liabilities:		16. Net Worth:	
17. Phone Numbers: Home:		Work:	Cell:
18. Fax:		19. Email:	

Section B - Insurance Details

Proposed Death Benefit \$	Proposed Product:
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Existing Coverage

Insurance Company	Policy Number	Type	Year Issued	Face Amount	To be Replaced?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there a trial or formal application pending? Yes No (If yes, what company?)

Have you ever been declined or rated? Yes No (If yes, provide details in "Remarks")

Case Recently Shopped? Yes No (If yes, give details on Date, Carrier, Health rating, Will it be placed?)

Section C - Physician Information

Please list all physician's seen in the past 5 years. Please list any additional physicians in "Remarks" section.

Name - Address - Phone	Type of Physician	Date Last Consulted	Reason/Results

Section E – Medications

List all Current Medications, Dosages and Prescribing Physician:

Section F – General Risk

Tobacco Use: Yes No | Type: _____ | Date Last Used: _____

Height: _____ Weight: _____
Has weight changed more than 10 lbs in the past year? Yes No (If yes, provide details in "Remarks")

Have you been advised to seek treatment or been treated for alcohol or substance abuse? Yes No
(If yes, provide details in "Remarks").

In the past five years, have you been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? Yes No

Have you traveled or resided in a foreign country or plan to in the future? Yes No
(If yes, provide details in "Remarks").

Section G - Family History

Has any family member (parents / siblings) – been diagnosed with any of the following conditions:

Cancer, diabetes, Heart or Cardiovascular Issues, Huntington’s Disease or Kidney Disease - Yes No

	Age if living	Present Health	Age deceased	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____

Family History Details:

Section H - Agent Information

Name: _____ | Phone Number: _____ | Fax: _____

Email address: _____ | Date: _____

Additional Remarks / Notes: (Please Identify the Question you are answering.)

Financial And Medical Records Authorization

(This authorization complies with the HIPAA Privacy Rule)

Give completed and signed copy to proposed insured



PRIMARY INSURED

Name (First, M.I., Last)	Date of Birth	Social Security No
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ADDITIONAL INSURED

Name (First, M.I., Last)	Date of Birth	Social Security No
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AUTHORIZATION

I authorize National Brokerage and the agent/broker named below, Insurance support organizations (such as MIB, Inc), the companies listed at the bottom and their reinsurers, agents, employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other Insurance coverage, or has provided payment, medical care, treatment, supplies, 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 individuals/entities named above. 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 to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate 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 Company(s).

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, by sending a written request for revocation to National Brokerage 6225 North Meeker Place Suite 100 Boise, ID 83713 Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers have relied on this authorization or to the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule). I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I do not sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

Companies to Which This Authorization Applies:		
Aegon	Life Capital Finance, LLC	Presidential
Allianz Life	Life of the Southwest	Prudential / Pruco
American General	Lincoln Benefit	Reliastar
American National	Lincoln National	SBLI
Assurity Life	Metropolitan	S.B.S. Marketing
Aviva	Minnesota Life	Security Life of Denver
AXA/Equitable	Mountain Financial Group	Select Brokerage. Services Inc
Banner Life	Mutual Trust (MTL)	Sun Life of Canada
ECC Marketing	National Brokerage	Transamerica
Fidelity Life Association	National Life Ins. Co.	Transamerica – Family Markets
Genworth	Nationwide	United Home
Guaranty Income Life / GILICO	New York Life	United of Omaha
Guardian	North American	United States Life
Hartford	Pacific Life	West Coast Life
Hooper Holmes	Penn Mutual	Western Reserve Life
IBU	Phoenix Life	William Penn
ING	Pioneer Insurance Brokerage LLC	
John Hancock	Portamedic	
Lafayette Life	Principal	
Liberty Life	Protective	

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient:

Signature of Agent/Broker Name of Agent/Broker Date

Signature of Proposed Insured/Patient or Personal Representative Date

Signature of Additional Proposed Insured/Patient or Personal Representative Date