

# 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.

<b>Companies to Which This Authorization Applies:</b>		
Aegon	Lafayette Life	Protective Life
Accordia	Liberty Life	Prudential / Pruco
Advantage Insurance Network	Life of the Southwest	Reliastar
Allianz Life	Lincoln Benefit	SBLI
American General	Lincoln National	S.B.S. Marketing
American National	Metropolitan	Sagicor
Assurity Life	Minnesota Life	Securian
Athene	Mountain Financial Group	Security Life of Denver
AXA/Equitable	Mutual of Omaha	Select Brokerage Services Inc
Banner Life	Mutual Trust (MTL)	Symetra
Fidelity Life Association	National Brokerage	Transamerica
Genworth	National Life Ins. Co.	Transamerica – Family Markets
Guaranty Income Life / GILICO	Nationwide	United Home
Guardian	North American	United of Omaha
Hartford	Penn Mutual	United States Life
Hooper Holmes	Phoenix Life	Voya
ING	Portamedic	William Penn
John Hancock	Principal Life	Zurich

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:

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Signature of Agent/Broker                      Name of Agent/Broker                      Date

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Signature of Proposed Insured/Patient or Personal Representative                      Date

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Signature of Additional Proposed Insured/Patient or Personal Representative                      Date