AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: _____

THE COMPANIES:	
Accordia Life and Annuity Company	P.O. Box 305027, Nashville, TN 37230-5027
Allianz Life Insurance Company	P.O. Box 1344, Minneapolis, MN 55440-1344
American Family Life Assurance Company of Columbus (AFLAC)	1932 Wynnton Road, Columbus, GA 31999-0001
American Family Life Assurance Company of New York (Aflac NY)	22 Corporate Woods Boulevard, Albany, NY 12211
American General Life and Accident	431N American General Center, Nashville, Tennessee 37250-0001
American General Life Companies	P.O. Box 4373, Houston, Texas 77210
American National Insurance Company	One Moody Plaza, Galveston, Texas 77550
Assurity Life Insurance Company	2000 Q Street, Lincoln, NE 68503
AXA-Equitable Life	80 Swamp Road, Farmington, CT 06032
Banner Life Insurance Company	3275 Bennett Creek Ave., Frederick, MD 21704
Companion Life Insurance Co. (Mutual of Omaha)	888 Veterans Memorial Highway, St. 515, Hauppauge, NY 11788
Fidelity Guaranty Life Insurance Company	1001 Fleet St., Baltimore, MD 21202
Fidelity Guaranty Life Insurance Company of New York	1001 Fleet St., Baltimore, MD 21202
First Symetra National Life Insurance Company of NY	260 Madison Ave, 8th floor, New York, NY 10016
Foresters	789 Don Mills Road, Toronto, Ontario M3C1T9
Genworth Life Insurance Company	PO Box 10720, Lynchburg, VA 24506-0720
Integrity Life Insurance Company	PO Box 5720, Cincinnati, OH 45201-5720
John Hancock	PO Box 55765, Boston, MA 02205-5765
Lafayette Life Insurance Co. (non-NY only)	400 Broadway, Cincinnati, OH 45202-3341
Life Ins. Co. of Southwest (National Life Group)	One National Life Drive, Montpelier, VT 05604
Lincoln Financial Group	350 Church Street, Hartford, CT 06103-1106
Massachusetts Mutual Life Ins. Co. (Mass Mutual)	1295 State Street, Springfield, Massachusetts 01111-0001
Met Life Insurance Company	One City Place 185 Asylum, 7th Floor, Hartford CT 06103
Minnesota Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
MONY Life Insurance Company	80 Scott Swamp Rd, Farmington CT 06032-2847
Mutual of Omaha	Mutual of Omaha Plaza, Omaha, NE 68175
National Integrity Life Insurance Company	15 Matthews Street, Suite 200, Goshen, NY 10924-1995
National Life of Vermont	One National Life Drive, Montpelier, VT 05604
Nationwide Life Insurance Company	One Nationwide Plaza, 1-10-04, Columbus, OH 43215
Nationwide Life and Annuity Insurance Company	One Nationwide Plaza, 1-10-04, Columbus, OH 43215
North American Company	535 West Van Buren, Chicago, IL 60607
Pacific Life	700 Newport Center Drive, Newport Beach, CA 92660-6397
Pacific Life and Annuity Company	700 Newport Center Drive, Newport Beach, CA 92660-6397
Penn Mutual Life Insurance Company	600 Dresher Road, Horsham, PA 19044
Phoenix Life Insurance Company	PO Box 8027, Boston, MA 02266-8027
Principal Life Insurance Company (NY)	Des Moines, Iowa 50392-0001
Principal National Life Insurance Company	Des Moines, Iowa 50392-0001
Protective Life Corporation	2801 Highway 280 South, Birmingham, AL 35223
Protective Life and Annuity (NY)	Two Ravina Drive, Suite 960, Atlanta, GA 30346
Prudential Select Brokerage	Attn: Underwriting, 13001 County Road 10, 4th Floor, Plymouth, MN 55442
ReliaStar Life Insurance Company(VOYA)	909 Locust Street, Des Moines, Iowa 50309-2803
Securian Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
Security Life of Denver (VOYA)	909 Locust Street, Des Moines, Iowa 50309-2803
Symetra Life Insurance Company	777 108th Ave NE, Suite 1200, Bellevue, WA 98004-5135
Transamerica Life Insurance Company	4333 Edgewood Road NE, Cedar Rapids, Iowa 52499
The United States Life Insurance Company NY (USL)	P.O. Box 4373, Houston Texas 77210-4373
William Penn Insurance Company	PO Box 519, Garden City, NY 11530
United of Omaha	3301 Dodge Street, Omaha, NE 68131
Zurich American Life Insurance Company	7045 College Boulevard, Overland Park, KS 66211-1523
Zurich American Life Insurance Company of New York	7045 College Boulevard, Overland Park, KS 66211-1523

The terms that follow have the respective meanings when used in this Authorization:

INSURANCE SUPPORT ORGANIZATIONS:	Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU:	Medical Information Bureau, Inc.
AUTHORIZATION:	Authorization to Obtain and Disclose Information

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits;

Signed at _____ this _____ day of _____ 20____

_____ _____

Proposed Insured Signature | Proposed Owner's Signature

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

_____ _____

Name of Minor Child | Signature of Minor Child's Authorized Representative

_____ _____

Name of Minor Child's Authorized Representative | Witness (Broker)

Authorization for Release of Health-Related Information - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, 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 personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). 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. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 Companies.

This authorization shall remain in force for 24 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 The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment 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 record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured, Patient, or Personal Representative x	Date
Signature of Proposed Insured, Patient, or Personal Representative x	Date
Signature of Proposed Insured, Patient, or Personal Representative x	Date
Description of Personal Representative's Authority or Relationship to Patient	

Authorization for Release of Personal Psychotherapy Notes - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, 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 personal health information solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record as described above without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 Companies.

This authorization shall remain in force for 24 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 The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment 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 record as described above, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured, Patient, or Personal Representative x	Date
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Description of Personal Representative's Authority or Relationship to Patient	