Brokers' Service
MARKETING GROUP
Life Insurance • Annuities • Long Term Care

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS AUTHORIZATION COMPLIES WITH HIPAA PRIVACY REGULATIONS

The terms that follow have the respective meanings when used in this authorization:
Authorization: To obtain and disclose information. **Insurance Support Organization:** Medical Information Bureau, Inc. and/or Consumer Reporting Agency. **Bureau:** Medical Information Bureau, Inc.

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

AIG/American General	Brokers Service Companion Life	ING/ReliaStar of New York	Lincoln Life	Protective Life	The Hartford	Western Reserve
Allianz	Genworth Life & Annuity	ING/Security Life of Denver	Lincoln Benefit Life	Prudential Life	TransAmerica	William Penn
American National	Genworth Life of New York	ING/ReliaStar	MetLife Investors	S.B.L.I.	United of Omaha	
AXA Equitable		John Hancock	North American	Scantech/LabOne	US Life	
Banner Life			Ohio National	Sun Life of Canada/ Keyport	West Coast Life	
			Principal Life			

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 ("My Providers), ... and any insurer, reinsurer, insurance support organization, financial source, and employer to disclose the types of information listed below when this authorization is presented. I authorize all said sources listed above, except the Bureau, to give such records or knowledge to Brokers' Service Marketing Group.

This information includes my entire medical record and any other protected health information concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.... This also includes information on other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this authorization so that the insurance companies named above and their reinsurers may: 1) determine my insurability and underwrite my application for coverage by making eligibility, risk rating, and policy issuance 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 insurance companies named above.

Those parties named above may disclose the information that they have collected. They may disclose this information to: 1) other insurers to which I have applied or may apply; 2) reinsurers; 3) the Bureau; or 4) other persons who perform business, professional, or insurance services for them.

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 acknowledge receipt of this notice and understand that I have the right to revoke this authorization in writing, at any time, by sending a written request to Brokers' Service Marketing Group. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that any of the insurance companies named above has 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 redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, any of the insurance companies named above may not be able to process my application, or if coverage has been issued, may not be to make any benefit payments.

Signed at ______________________________ Date ____________ 20 ______
(City) (State)

Agent's Signature: ______________________ Print Name: ______________________

Print Insured's Name & Address ______________________________
(Name) (Address: Street, City, State)

Signature of Proposed Insured ☒ ______________________ SS# ______________

PLEASE HAVE PROPOSED INSURED SIGN WHERE INDICATED BY ☒