AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION - HIPAA COMPLIANT

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Name of Proposed Insured Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy manager, 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, prescription history, medication prescribed, and any other protected health information concerning me to the insurance companies and /or settlement companies names below. This includes information on the diagnoses and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes the 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 my agreements I have made to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the insurance companies and/or settlement companies named below 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 benefits; 4) administer coverage; 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance and /or settlement companies named below.

This authorization should 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 providing written notification to the Office of the President of Advantage Insurance Network, INC.I understand that a revocation is not effective to the extent that any of My providers has already relied on this Authorization to disclose information about me or to the extent that the insurance and/or settlement companies named below 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies named below except as authorized by me or as required by law.

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 or release my complete medical record, the insurance and/or settlement companies named below may not be able to process my application, or if the coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

AIG
AXA Equitable
Brighthouse Financial
Foresters Financial
Genworth
Global Atlantic
Guardian Life
John Hancock
Lincoln National Life
Massachusetts Mutual
Minnesota Life/Securian
Mutual of Omaha (United of Omaha)
Mutual of Omaha (Companion Life)
Nationwide
New York Life
North American
OneAmerica
Pacific Life
Penn Mutual
Principal Life Insurance
Principal National Life
Protective Life
Prudential
Standard Insurance
Symetra
Transamerica Life
U.S. Life
Voya Financial
Zurich American
Advantage Insurance Network
Abacus Settlements
Rosenblatt Brokerage LLC

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Signature of Proposed Insured Date