Authorization to Obtain and Disclose Health-Related Information
This authorization complies with the HIPAA Privacy Rule

THIS IS NOT AN APPLICATION FOR INSURANCE.
NO INSURANCE WILL BE ISSUED AS A RESULT OF THE COMPLETION OF THIS FORM.
This is a preliminary informational request by us for information in connection with evaluating possible insurance coverage. No insurance will be issued as a result of your completion of this form or on the basis of confidential information about you which may be provided to us by you or any other person in connection with this form. A separate, completed application must be signed by you to obtain insurance.

Name of proposed insured (please print)_____ Date of birth:_____

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager 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"), and any affiliate thereof, to disclose my medical records and any other information concerning me that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to Kornreich-NIA, Kornreich-NIA's data collection agents including, without limitation, Parameds.com, and to the insurance companies, reinsurers and subsidiaries of each of the insurance companies listed below (collectively, "The Insurance Companies"). This Authorization includes disclosure of information concerning (i) the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, (ii) the diagnosis and treatment of mental illness, and (iii) the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with My Providers or any affiliate thereof to restrict my medical records and any associated HIPAA-protected health information and I instruct My Providers and such Banks and its affiliates 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 may determine whether they might consider offering me insurance coverage or benefits. I understand that no insurance will be issued except on the basis of a signed, completed application by me of the respective Insurance Company. This Authorization shall remain in force for 30 months following the date of my signature below. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Kornreich-NIA. I understand that a revocation is not effective to the extent that any of The Insurance Companies have relied on this Authorization. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed 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, The Insurance Companies may not be able to determine whether they might consider offering me insurance coverage or benefits. I acknowledge that I have received a copy of this authorization. I agree that a copy of this Authorization shall be as valid as the original.

X _____ _____
Signature of Proposed Insured Date

Advanced Settlements, LLC	ING-Security Connecticut	Pacific Life Insurance Company
American General Life Insurance Co.	Jefferson-Pilot Life Ins. Co.	Pacific Life and Annuity Company
American General Life Ins. Co. of NY	John Hancock Insurance Company	Phoenix Life Insurance Company
American Mayflower Life Ins. Co. of NY	John Hancock Variable Life Ins. Co.	Phoenix Life Annuity Company
Bankers Life of NY	Lincoln Life & Annuity	Principal Life
Banner Life	Lincoln Life and Annuity Co. of NY	Prudential/PRUCO
Berkshire Life Insurance Company	Lincoln National Life Company	Principal Life Insurance
Companion Life Insurance Company	Manufacturers Life Ins. Co. of America	Security Mutual
C.N.A. Life / Valley Forge Life	Manufacturers Life Ins. Co. (USA)	Sun Life Financial
Fidelity & Guaranty Life Ins. Co.	Massachusetts Mutual Life Ins. Co	Transamerica Life
First UNUM	Metropolitan Life Insurance Company	Transamerica Occidental Life Ins. Co.
GE Financial Assurance	MONY	Travelers Life Insurance Company
GE Capital Assurance	MONY Life of America	Travelers Life & Annuity Company
GE Life & Annuity Assurance Company	Nationwide Life Ins. Co.	Union Central
General American Life Ins. Co.	Nationwide Life & Annuity	United of Omaha
Guardian Life	Nationwide Life & Annuity of America	UNUM/Provident
Guardian Life Ins & Annuity	New England Life Insurance Company	US Life Insurance Company
ING-Security Life of Denver Ins. Co.	New York Life Insurance Company	US Financial Life Insurance Company
ING-ReliaStar Life Insurance Company	New York Life Insurance & Annuity Co.	West Coast Life
ING-ReliaStar Life Ins. Co. of NY	Old Line Life	William Penn

Please list all Doctors / Hospitals seen over the last 10 years. For further comments, use reverse side.

PHYSICIAN LISTING

Insured's Name_____

Name of Personal Physician or
Hospital / Medical Facility _____

Address_____

Date & reason for last visit
& list medication prescribed_____

_____

Phone _____ Fax _____

Dr's Specialty _____

==========

Name of Personal Physician or
Hospital / Medical Facility _____

Address _____

Date & reason for last visit
& list medication prescribed_____

_____

Phone _____ Fax _____

Dr's Specialty _____

==========

Name of Personal Physician or
Hospital / Medical Facility _____

Address _____

Date & reason for last visit
& list medication prescribed _____

_____

Phone _____ Fax _____

Dr's Specialty _____

Worksheet Application. Please complete & sign. Use reverse side if needed for further comments.

Name_____ **Date of birth**_____ **Sex**_____ **Marital status**_____

S.S. #_____ **Birthplace**_____ **Citizen of**_____

Driver's license #_____ **State**_____ **Expires**_____

Have you used any tobacco in the last 12 months? Yes____ **No**____ **If "Yes" -what type:**_____

Have you ever used any form of tobacco? Yes____ **No**___ **If "YES"- when did you stop?**_____

Residence _____ **years there**_____

Previous address_____ **years there**_____

Home telephone_____ **Home Fax**_____

Business telephone_____ **Business fax** _____

Employed by_____ **Date employed**_____

Business address_____

Occupation _____ **Job Description**_____ **Job title**_____

Salary_____ **Bonus**_____ **Unearned income**_____ **Net worth**_____

Name of policyowner_____ **Relationship to you**_____

Owner's S.S. # or tax I.D. #_____

Owner's Address _____

Primary Beneficiary_____ **Relationship to you**_____

Secondary Beneficiary_____ **Relationship to you**_____

Names and dates of birth of spouse and children_____

_____

Personal physician_____

Address_____

Date and reason for last visit_____

DETAILS OF ANY SERIOUS MEDICAL PROBLEMS_____

Present height_____ **Present weight**_____ **Medication being taken**_____

Within the last 12 months have you been in a motor vehicle accident, convicted of a moving violation or received driver's license restriction of revocation? Yes____ **No**____ **Details**_____

_____

Please complete details for all life/disability insurance inforce:

Insurance	**Amount**	**Year Issued**	**Outstanding Loans**

Do you contemplate foreign travel or change of residence? Yes____ **No**____ **Details**_____

Will this Ins. replace any existing coverage: Yes____ **No**____ **Details**_____

Have you been examined for life insurance in the past 12 months? Yes____ **No**____

Have you ever been declined or charged an extra premium for insurance? Yes____ **No**____ **Details**_____

If "YES" Company_____ **Amount**_____ **Date**_____

Have you ever engaged in: 1.Scuba Diving_____ **2.Parachute Jumping**____ **3.Racing**____

4.Flying other than a commercial passenger____ **5.Other hazardous sports**_____

If "YES" to any of the above please give details_____

Do you participate in any regular physical exercise program: Yes____ **No**____ **Details**_____

Do you use alcoholic beverages: Yes____ **No**____

Details (Note Type,Quantity and Frequency)_____

Date _____ **Signature of proposed insured** X _____