Preliminary Information and Authorization

Proposed Insured Name:	Address:
Date of Birth	Phone Number:
Last 4 Digits of SSN:	Gender
Height	Weight

Tobacco Use: Yes _____ No _____
If yes, please provide details.
____
____

Family History

Relative	State of Health or Cause of Death	Age if Living	Age at Death

Medical History

Summary of Medical History:
____
____
____
____

Medication (s):
____
____
____
____

Name, address, and phone number of current primary care physician for complete medical records.
____
____
____
____

Name, address, and phone # of any medical specialists consulted in the last 5 years. List EKG's, X-rays, and other diagnostic tests. ____________________ ____________________ ____________________ ____________________
Have you had any hospitalizations in the last 5 years? If yes, please provide details to include hospital name and dates. ____________________ ____________________ ____________________ ____________________ ____________________

Signature: ____ Date: ______________

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

Name of Proposed Insured/Patient (please print)

Date of Birth

Social Security Number

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 the following:

Accordia Life
American General Life Insurance Company
American National Insurance Co.
American National Insurance Co. of New York
American Network/Penn Treaty
Assurity Life Insurance Company
Aviva USA, its subsidiaries or reinsurer(s)
Banner Life
Brighthouse Financial, its subsidiaries or reinsurer(s)
Cincinnati Life
Columbus Life, its subsidiaries or reinsurer(s)
Companion Life Ins. Co.
Daly Insurance Brokerage Services, LLC
Equitable
Exceptional Risk Advisors
Genworth, its subsidiaries or reinsurer(s)
G.E. Capital LTC
Global Atlantic Financial Group, its subsidiaries or reinsurer(s)
ING–ReliaStar Life Insurance Co.
ING–ReliaStar Life Insurance Co. of New York
ING–Security Life of Denver Insurance Co.,
Indianapolis Life, its subsidiaries or reinsurer(s)
John Hancock, its subsidiaries or reinsurer(s)
Lafayette Life, its subsidiaries or reinsurer(s)
Lincoln National Life, its subsidiaries or reinsurer(s),
Minnesota Life, its subsidiaries or reinsurer(s),
Metropolitan Life Insurance Company, its subsidiaries or reinsurer(s) and MetLife Ins. Co. USA
Mutual of Omaha, its subsidiaries or reinsurer(s),
National Life Group, its subsidiaries or reinsurers
Nationwide, its subsidiaries or reinsurer(s)
New York Life, its subsidiaries or reinsurer(s),
North American, its subsidiaries
Pacific Life Insurance Company
Penn Mutual, its subsidiaries or reinsurer(s)
Phoenix, its subsidiaries or reinsurer(s)
Principal National Life and Principal Life Insurance, its subsidiaries or reinsurer(s),
Protective Life, its subsidiaries or reinsurer(s),
Prudential, its subsidiaries or reinsurer(s),
SBLI/Centrian, Sun Life of Canada, its subsidiaries or reinsurer(s),
Symetra, its subsidiaries or reinsurers(s),
Transamerica, its subsidiaries or reinsurer(s),
United States Life Insurance Company
Zurich American Life Insurance
Daly Insurance Brokerage Services, LLC, etc.
(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 entail 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 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. I understand the information obtained by use of this Authorization will be used by The Companies to determine eligibility for benefits under an existing policy and for other business purposes in connection with the insurance relationship. Any information obtained will not be released by said companies to any person or organization EXCEPT the reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, other business purposes, or as may be otherwise lawfully required or as I may further authorize.

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 I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Daly Insurance Brokerage Services, LLC, 231 Farmington Avenue, Farmington, CT 06032. Attention Authorization Administrator. I understand that a revocation is not effective to extent that any of My Providers has relied on the 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 Date

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Print name of signature above

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Description of Personal Representative's Authority or Relationship to Patient