



Agent Support Group

A Member of Lifemark Partners

New York City
Long Island
Westchester

Authorization for Release of Health-Related Information To Agent Support Group This Authorization Complies With the HIPAA Privacy Rule

Name of Insured/Patient _____ Date of Birth _____ S.S.# _____

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 protected health information concerning me to Agent Support Group and its agents, employees, and representatives. 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.

By my signature below, I acknowledge that any 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 reservation.

This protected health information is to be disclosed under this authorization to that Agent Support Group 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 through Agent Support Group.

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 understand that I have the right to revoke this authorization in writing, at any time, by sending the written request of revocation to Agent Support Group at 99 Park Avenue, New York, NY 10016; 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 the Agent Support Group 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 federal rules governing privacy and confidentiality of health information.

The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of _____, affiliated insurance companies and their reinsurers.

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, Agent Support Group 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 of Personal Representative

Date

Description of Personal Representative's Authority or Relationship to Patient

Companies to which this authorization applies to:

- | | | | |
|--------------------------|-------------------------|-------------------------|----------------------|
| 21 st Century | Credit Suisse | Lifestyle Settlements | Protective Life |
| Advanced Settlements | Eastport Capital | Lifemark Partners | Prudential Financial |
| Allianz Life | Empire General | Lincoln Benefit Life | Reliastar ING |
| Allstate Life | EMSI | Lincoln Life & Annuity | Scan Tech Solutions |
| Allstate Life of NY | Exam One | Lincoln Financial Group | Security Mutual |
| American General | First Penn Pacific | Mediconnect | Sun Life |
| American National | Genworth Financial | Metropolitan Life | Transamerica |
| ANICO | Genworth Life & Annuity | Mutual of Omaha | Union Central |
| AVS | General American | National Integrity | UNUM |
| AXA Equitable | Goldman Sachs & Co. | Nationwide | US Financial |
| Bankers Life | Hartford Life | Pacific Life | US Life |
| Banner Life | Hooper Holmes | Parameds.com | USG Annuity |
| Berkshire Life & DI | Indianapolis Life | Phoenix Life | Welcome Funds |
| Case Clearing House | Integrity Life | Portamedic | West Coast Life |
| Columbian Life | John Hancock | Premium Funding Group | William Penn |
| Companion Life of NY | Lexnet L. P. | Principal Financial | |
| Coventry First | Life Settlements | Presidential Life | |



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Hawthorne, NY 10532
(914) 345-9666 Phone
(914) 592-1455 Fax

99 Park Avenue
11Th Floor
New York, NY 10016
(212) 697-2025 Phone
(212) 292-5146

295 Northern Blvd
Great Neck, NY 11021
(516) 482-8282
(516) 482-8323

Agent Name _____

Address _____

City, State, Zip _____

Phone _____

Sign on bottom as witness

Preliminary Inquiry

Proposed Insured Information

Full Name _____ Date of Birth _____

Home Address _____ Place of Birth _____

Citizen Of What Country? _____

Occupation _____ Employer _____ Social Security # _____

Business Address _____ Applicant's Height _____

Applicant's Weight _____

Has the proposed insured ever used any form of tobacco or nicotine-based products? Yes No

If "Yes", when did the proposed insured last use tobacco or nicotine-based products? _____ (Month/Year)

Type _____ Quantity _____

Amount to Be Insured _____ Plan or Policy Desired _____

Beneficiary _____

	Name & Address	Date	Illness	Duration
What physician did you last consult?				
What physicians have you consulted during the past five years?				
In what clinics, hospitals or sanitariums have you ever been treated?				
Who is your personal physician? When did you last consult this physician?				
REMARKS Has applicant ever been declined or postponed for insurance or offered a policy different from that applied for?				

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health, to furnish Agent Support Group, its insurers or reinsurers any such information.

This Authorization will be valid for two years after the date of signing. A photographic copy of this Authorization shall be as valid as the original.

Dated at _____ this _____ day of _____, 20 ____.

Full Signature of Proposed Insured (if Adult) or Applicant

Witness - Licensed Agent

This is not an application for the issuance of life insurance.

12. PROPOSED INSURED

- a. Height in shoes _____ / _____ Weight in clothes _____
feet inches pounds
- b. Have you gained or lost more than 10 pounds in the last year? Yes No
- c. Are you now under observation or treatment? Yes No
- d. Have you been diagnosed by or received treatment from a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or Aids Related Complex (ARC)? Yes No
- e. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? Yes No

13. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN SEEN FOR:

- a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? Yes No
- b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? Yes No
- c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? Yes No
- d. Diabetes, thyroid, glandular or endocrinal disorder? Yes No
- e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? Yes No
- f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? Yes No
- g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? Yes No
- h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? Yes No
- i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? Yes No
- j. Anemia, hepatitis, or any blood disorder? Yes No
- k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? Yes No

14. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

- a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test (other than an HIV test) or treatment, or been advised to have any diagnostic test (other than an HIV test), surgery or treatment not yet completed? Yes No
- b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? Yes No
- c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been convicted of or plead guilty to, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? Yes No
- d. Do you currently use alcoholic beverages? Yes No
 If yes, what is the average number of drinks per day? 2 or less 3-5 6 or more.

15. FAMILY HISTORY

- a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? Yes No
- b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 12 through 15. (If necessary, use an additional page for additional details, **sign by applicant & date.**)

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility