McQueenKalligan
Insurance Services, Inc.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This Authorization complies with HIPAA, HITECH and GLBA 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, and insurance support organizations, my independent insurance representatives, and those persons and employees authorized to represent them, including those persons defined as "business associates" under the HITECH Act, may need to collect information on me in regard to proposed coverage.

Abacus Life Settlements |Accordia Life | AIG / American General | Ameritas |Allianz | Allianz Life of NY | American National |Assurity |AVS Underwriters | Banner Life | Brighthouse Financial | Cincinnati Life |Datafied |Equitable Life |Evergreen Settlements | Exam One |Fasano Associates |Global Atlantic | GLP Settlements |ITM 21st |John Hancock of NY | John Hancock USA (Man) | Legal & General America | Life Insurance Co. of the Southwest | Lincoln Life of NY | Lincoln National Life | Lincoln National Life of NY | Mass Mutual |Minnesota Life | Mutual of Omaha | National Guardian Life |National Life Group | Nationwide | Nationwide Financial | New York Life | North American | One America/State Life |Pacific Life | Peterson International | Principal Life Ins. Co.| Principal National Insurance Co. | Protective Life | Protective Life of NY | Prudential Ins. Co. of America | Pruco Life Insurance Co. | Sagicor |Saving Bank Life Insurance Co. of MA | Securian | Symetra | Transamerica Insurance Company | Transamerica of NY | United of Omaha | William Penn of NY

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 AIMCOR Enterprise Insurance Group (EIG) I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

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. This also includes information on other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits. This also includes genetic information about me or my family members.

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 file 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.

The parties named below 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 written request to the address listed below. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that any of the insurance companies named above 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 certain federal rules governing privacy and confidentiality of health information.

COMPLETED BY INSURED / PATIENT

Insured's Name: _____

DOB:_____ Social Security #:_____ DL #_____ DL ST: _____

Insured's Address: _____

City:_____ State:_____ Zip:_____ - _____

SIGNATURES

Signed At: _____ Date:_____ 20_____

Insured's Signature _____ Print Name: _____

Advisor's Signature:_____ Print Name: _____

COMPLETED BY AUTHORIZED PROCESSING OFFICE PERSONNEL

Information and records to be released to:

McQueen Kalligan Insurance Services Attn: _____

Mailing Address**:** _____

City:_____ State:_____ Zip:_____-_____

Phone:_____ Fax:_____ Email :_____