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|---|---------------------------------------|---|---------------------------------------|--|
| <input type="checkbox"/> American General | <input type="checkbox"/> First Penn | <input type="checkbox"/> Lincoln Benefit | <input type="checkbox"/> Protective | <input type="checkbox"/> United of Omaha |
| <input type="checkbox"/> Amerus | <input type="checkbox"/> GE Life | <input type="checkbox"/> Lincoln National | <input type="checkbox"/> Reliastar | <input type="checkbox"/> US Financial |
| <input type="checkbox"/> Banner | <input type="checkbox"/> Great | <input type="checkbox"/> Manulife | <input type="checkbox"/> Reliastar NY | <input type="checkbox"/> West Coast |
| <input type="checkbox"/> CNA | <input type="checkbox"/> American | <input type="checkbox"/> MTL | <input type="checkbox"/> Security | <input type="checkbox"/> William Penn |
| <input type="checkbox"/> Canada Life | <input type="checkbox"/> General | <input type="checkbox"/> Mass Mutual | <input type="checkbox"/> Connecticut | <input type="checkbox"/> Zurich |
| <input type="checkbox"/> Clarica | <input type="checkbox"/> American | <input type="checkbox"/> MONY | <input type="checkbox"/> Southland | |
| <input type="checkbox"/> Conseco | <input type="checkbox"/> Guardian | <input type="checkbox"/> New York Life | <input type="checkbox"/> State Life | |
| <input type="checkbox"/> F&G | <input type="checkbox"/> Hartford | <input type="checkbox"/> North American | <input type="checkbox"/> SunLife | |
| <input type="checkbox"/> Empire General | <input type="checkbox"/> Connecticut | <input type="checkbox"/> Old Republic | <input type="checkbox"/> Travelers | |
| <input type="checkbox"/> First Colony | <input type="checkbox"/> John Hancock | <input type="checkbox"/> Prudential | <input type="checkbox"/> Transamerica | |

Any of the companies indicated above will be referred to as "the Company"



Authorization

For Underwriting and claim settlement purposes regarding me or any child(ren) under the age of 15 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and MIB Group, Inc. (MIB) to give the Company information about me or such child(ren) including:
 - Personal information and data;
 - Medical information, records and data (such as: drugs prescribed; medical test results; and information about sexually transmitted diseases);
 - Information related to alcohol and drug abuse and treatment;
 - Information, records, and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immuno-deficiency Virus (HIV) test results; and
 - Information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give any of the Companies listed above any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data received that the Company receives pursuant to this Authorization will be used and maintained by any of the Company described in its **Consumer Privacy Notice**, a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for any of the above mentioned Companies on the insurance applied for or an existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If Underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form

SIGNATURES: (Parent or Guardian, if a proposed insured is under age 15, sign on line for proposed insured)

Proposed Insured #1 _____ Date _____
 Print Name of Proposed Insured #1 _____
 Witness : _____ Date _____