

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

American General/U.S. Life

I hereby authorize and request any licensed physician, medical practitioner, hospital, clinic or other medical 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, or that of any member of my immediate family proposed for insurance to give to American General Life Insurance Company and its reinsurers any such information. A photographic copy of this authorization shall be valid as the original. Receipt is hereby acknowledged of the notices made a detachable part of this application pertaining to the Fair Credit Reporting Act and the Medical Information Bureau. I represent that the statements and answers recorded above are true and complete to the very best of my knowledge and belief.

Hartford

I authorize Hartford Life or Hartford Life and Accident Insurance Company (Hartford) to complete a Personal History Interview and to obtain an Investigative Consumer Report on me or on my children. I authorize the release of any medical or non-medical information that relates to: (1) past or current health conditions including illnesses; sicknesses; diseases; disabilities; disorders; accidents; or injuries; (2) confinements in any hospital; medical facility; or medical clinic; (3) outpatient treatment in any hospital; hospital emergency room; medical facility; or clinic; (4) treatment for alcohol abuse; drug abuse; or mental health protected by Federal Law. This information may be released by any person or organization that has records or knowledge of my health or of the health of my children, if they are applying for insurance. This includes any doctor; medical professional; health practitioner; therapist; counselor; hospital; clinic; insurer; reinsurer; consumer reporting firm; employer or the Medical Information Bureau (MIB). This information may be released for the purpose of determining eligibility for insurance under a new or existing policy. This information may be released to Hartford or to their legal representative. I understand that the MIB will release records of information only to Hartford. Hartford may release the information in their file(s) to: their reinsurers; the MIB; any other insurance company to whom I or my children apply for life or health insurance; or other persons and/or organizations performing business or legal services in connection with this application or a claim.

Mass Mutual Life Insurance Company

I have received the Notice about the Medical Information Bureau, Inc. (MIB). I have also received the Notice about the Fair Credit Reporting Act. I understand and authorize an investigative report to be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health (or my children and their health if juvenile insurance), to make such information available to the Company and its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, MIB, or other organization. I agree that a photo copy or facsimile of this authorization may be used to obtain information.

John Hancock USA

I hereby give permission to any physician, medical care provider, hospital, clinic, laboratory, insurance company or MIB, Inc. (The Medical Information Bureau) or any other similar person or organization to give The Company and to its reinsurers, information about me or any of my minor children who are to be insured. The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. Although information related to drug or alcohol abuse at any time, but any revocation will not affect such information that has already been collected and relied on by The Company. Information collected under this Authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes. I understand that I have a right to receive a copy of this form. I agree that a photocopy of this form will be as valid as the original. This authorization will be valid for two years from the date shown below. I acknowledge receipt of the Notice of Disclosure of Information

Lincoln Financial Group, Inc.

I AUTHORIZE any medical professional, hospital, clinic, medical care institution, insurer, the Medical Information Bureau, Inc. consumer reporting agency, Social Security Administration, employer, or other person having records or knowledge of me or my family members' physical or mental health, or any other information bearing on my (our) insurability, to give Lincoln National Life Insurance Company and its reinsurers or any consumer reporting agency acting on the Company's behalf, any such information. This shall include all information about my (our) medical history, diagnosis, treatment, and prognosis including information regarding alcohol and drug abuse. I AUTHORIZE the Insurance Company to have blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders or the presence of medication, drugs or nicotine. I AUTHORIZE the Insurance Company to disclose the results of these tests to the Medical Information Bureau described in the Important Notice. I UNDERSTAND THAT my (our) medical records may be protected by certain Federal Regulations especially as they apply to any drug or alcohol abuse data. I understand that I (we) may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected. This authorization shall be valid for a period of two years after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such a report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, ___I do, ___I do not request to be interviewed. I ACKNOWLEDGE the receipt of the "Important Notice" containing Fair Credit Report Act and Medical Information Bureau, Inc. information.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or 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 give to the life insurance companies and companies listed on this form and their reinsurers at the time of my signature any such information. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency utilized by the insurance company to collect and transmit such information. The purpose of this authorization is to determine my eligibility for and apply for insurance products and services from the life insurance companies listed below. I understand that I may refuse to sign this authorization but that if I do refuse to sign, the companies listed below may not be able to fulfill the purpose of this authorization. This authorization shall be valid for 24 months from the date signed below, unless I revoke it, in writing. I understand that I may revoke this authorization at any time by writing to BISYS; however, any action taken in reliance on this authorization prior to the notice of revocation shall be valid. I acknowledge that the information to be disclosed may be protected under state and federal privacy laws and regulations. Once this information is disclosed, it may be subject to redisclosure and no longer covered under those laws and regulations. A photocopy of this authorization shall be as valid as the original, and I understand that I will be given a copy of this authorization. ,AIG, American General/U.S. Life, American Viatical Services, LLC, The August Group, AXA/Equitable, Banner, Banyan Life Financial, BISYS Insurance Services, BISYS-Potomac, Chase Insurance, CMS, CNA/Valley Forge, COVENTRY, Empire General, EMSI, F & G Life, Fasano Associates Inc., Finestone Strategy Partners, First Colony, General American, Hartford, ICMG, Indianapolis Life, ING, Jefferson-Pilot, John Hancock, Lincoln Benefit, Mass Mutual, MCC/Sierra, Metropolitan, MONY, Nationwide, New England, New York Life, North American, Pacific Life, Park Venture, Penn Mutual, Phoenix Life, Premium Life, LLC., Presidential Life, Principal, Protective, Prudential, Rangetree, Sun Life of Canada, Travelers, 21st Services, United of Omaha, West Coast Life and XE-R, LLC. I have received a copy of the Fair Credit Reporting Act Notification and the Exchange of Information (Medical Information Bureau).

Print Proposed Insured Name

Signature

Date

Print Proposed Insured Name

Signature

Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned individual, authorize the disclosure of my protected health information (“PHI”) as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 as follows:

1. **Classes of Persons Authorized to Disclose My Protected Health Information:** I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an “Authorized HCP”) having any PHI about me to disclose any and all of my PHI, except psychotherapy notes, as provided under this authorization. I acknowledge that all of my PHI in the possession of any Authorized HCP, except psychotherapy notes, is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2. **Classes of Persons Authorized to Receive My Protected Health Information:** I authorize each Authorized HCP to disclose my PHI under this authorization to Banyan Life Financial, a Georgia limited liability company, and its affiliates and any of their directors, officers, employees, agents, independent contractors, service providers or other representatives (each, an “Authorized Recipient”):

21 st Services	CV Starr	Lewis & Ellis	Olde Republic Life	Union Central
Advanced Planning Services	Eden Park	Liberty Mutual	Pacific Life	United of Omaha United States Life Ins. Co. of the City of New York
AIG LIFE	Empire	Life Asset Group	Park Venture Advisors Peachtree SLPO Finance Company, LLC	Universal Insurance Services
Allianz Life Insurance American General Life	Empire General Life F&G Life	Life Insurance Concepts Lincoln Benefit Life Ins. Co.	Penn Mutual	US Financial
American General Life of NY American Life Insurance Ins. Co. of NY	Fidelity Security	Lincoln Benefit Penn Mutual	Phoenix Life Insurance Co. Potomac Partners/ HK Ventures	US Life of NY
American National	First Colony Life Ins. Co. First Penn Pacific Life Ins. Co.	Lincoln Life of NY	Premium Life, LLC	Valley Forge Wealth Acceleration Group, LLC
AmerUs Life Ins. Co.	GE Capital Assurance GE Capital Assurance of NY	Lloyds of London	Presidential Life	West Coast Life William Penn Life Ins. Co. of New York
Aviva	GE Financial Assurance GE Life & Annuity Ins. Co. General American Life Ins. Co.	LS Funding Manufacturers Life Ins. Co. (Manualife Financial) Marquee Benefits, LLC	Principal Life	XE-R LLC Zurich Life
AXA American Viatical Services	GE Financial Assurance GE Life & Annuity Ins. Co. General American Life Ins. Co.	Mass Mutual Life Ins. Co. Metropolitan Life	Protective Life Ins. Co. Prudential Life	
Bankers Life of NY Banner Life	General Life Insurance Co. Guarantee Trust Life Ins. Co.	Mickelson Capital Consulting	Redwood Funding Trust I ReliaStar Life Ins. Co.	
Bedrock Funding	Guardian	MONY	ReliaStar Life of Denver	
Beneficial Life	Hartford Life Ins. Co.	Mutual of Omaha	ReliaStar Life of NY	
BISYS-Potomac Cambridge Financing Company	Himelsein Mandel Advisors IBEX Financial	National Western Life Ins. Co. Nationwide Life Ins. Co.	Ridge Capital Group	
Canada Life Assurance Co. Canada Life Assurance Co. of NY	Illinois Mutual	New England Financial	Security Connecticut Security Life of Denver	
CNA	Indianapolis Life	New York Life Ins. Co. New York Life Ins. Co. & Annuity Corp.	Security Mutual Life Ins. Co.	
Columbus Life	ING Institutional Marketing Consultants	New York Life Ins. Co. & Annuity Corp.	Security Mutual of NY	
Companion Life of NY	Jefferson Pilot John Hancock Financial Services	NFP Affiliates North American Company for Life & Health	Sun Life	
Continental Assurance Co.	Jefferson Pilot John Hancock Financial Services	North American Company for Life & Health	Sun Life of Canada	
Coventry Capital I	Lakeview Ins. Agency LTD	North American Life of NY Old Line Life	The Corben Group	
Credit Suisse Securities (USA)	Lakeview Ins. Agency LTD	North American Life of NY Old Line Life	TransAmerica Occidental Travelers Insurance	

3. **Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure:** This authorization shall apply to any and all of my health and medical data, information and records, except psychotherapy notes, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the sale and issuance of any life insurance policy under which my life is insured, or any resale, assignment or other transfer of such life insurance policy after its issuance, (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured and (3) to assess the value of a life insurance policy on my life.

4. **Expiration of Authorization:** This authorization shall remain valid until, and shall expire on, the date that is one (1) year after the date of my death.

5. **Right to Revoke Authorization:** I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6. **Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization.** I acknowledge and understand that no HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by such Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I acknowledge that I have received and retained a copy of this signed authorization for my future reference.

Signature of Individual

Print Name

Date: _____

If this Authorization is signed by the Individual's Personal Representative, you must provide a description of the Personal Representative's legal authority to act for the Individual: