HIPAA COMPLIANT AUTHORIZATION TO OBTAIN & DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Proposed Insured: _____

Date of Birth: _____ Social Security Number: _____

Records and Information obtained will be disclosed between the insurance company or companies listed below, and Windsor Insurance Associates, Inc. producers, contractors, employees, representatives and affiliates.

INSURERS

- Advanced Settlements
- AIG Partners Group
- Allianz
- American General Life Insurance Company
- American National
- Americo
- AXA
- Banner Life
- Brighthouse Financial
- CBIZ Life Insurance Solutions, Inc.
- Companion Life
- Fifth Avenue Financial
- Global Atlantic Financial Group
- Institutional Life Services, LLC
- John Hancock Life Insurance Companies
- Life Insurance Company of the Southwest
- Lincoln National Life Insurance Companies
- Lloyd's of London
- Mass Mutual
- Minnesota Life/Securian
- Mutual of Omaha
- National Life Group
- Nationwide Insurance Company
- New York Life Insurance Companies
- NFP Insurance Services
- North American Company
- Pacific Life
- Penn Mutual
- Phoenix Home Life
- Principal Financial Group
- Principal Life Insurance Company
- Principal National Life Insurance Co.
- Protective Life Insurance Companies
- Pruco Life Insurance Company
- Prudential Life Insurance Companies
- SBLI
- Symetra
- Total Financial & Insurance Services
- Transamerica Life Insurance Companies
- United of Omaha
- US Life
- Voya Financial
  - Reliastar Life Insurance Co
  - Reliastar Life Insurance Co. of NY
  - Security Life of Denver Ins. Co
- William Penn
- Windsor Insurance Associates, Inc.
- Zurich American Life Insurance Co.

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, (5) STD testing and treatment, (6) Genetic testing, (7) Sickle Cell testing and treatment, (8) lab results; (9) other insurance coverage (10) hazardous activities; (11) character; (12) general reputation; (13) mode of living; (14) finances; (15) occupation; and (16) other personal traits.

I understand that any Insurer named above, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect information for proposed insurance coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, Pharmacy Benefits Manager, hospitals, clinics, nurses, records, custodians, or anyone else located at:

Medical Facility: _____

Facility Address: _____

To release any and all records and information regarding the Proposed Insured listed above to and exchanged between the parties listed above and:

Requestor of Medical Information: _____

Requestor Address: _____

Broker/Agent/Agency/Firm: _____

Broker/Agent/Agency/Firm Address: _____

The Insurers named above and their reinsurers will use the information in order to determine whether I am insurable. The insurance producer may also use this information to help update and improve my insurance program.

Those parties named above 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) MIB; or (4) other persons who perform business, professional or insurance tasks for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use a secured internet-based system to store/access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This authorization will remain in effect for 36 months from the date of my signature below. I understand I may revoke this Authorization at any time by requesting such of my broker in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). My authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by their person authorized to act on their behalf.

I understand that I am not required to sign this authorization. I understand, however, that if I do not sign this authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

Signed at _____ this ____day of _____, (year)_____.

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative:

_____

Signature of Witness:_____
Complete if minor child is proposed for coverage:
Name of Minor Child: _____

Relationship of Representative to minor: _____