Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Dixon Wells, Inc. (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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 with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. 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 the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

_____	_____
Proposed Insured's Name	**Proposed Insured's Signature**
_____	_____
Signed and Dated On	**At (City, State, Zip Code)**

Agent/Witness Signature: _____ **Print Agent/Witness Name:** _____

Accordia Life, AIG, American General Life Insurance Company, American National Insurance Companies, Americo Financial Life and Annuity Company, Aviva Life and Annuity, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Life Insurance Company, Companion Life Insurance Company, Dixon Wells, Express Imaging Services, General Re Life Corp, Genworth Financial Family of Companies, Global Atlantic, Guardian Life Insurance Company, IFG, John Hancock, Lincoln National Life Insurance Company, MassMutual Life Insurance Company, Minnesota Life Insurance Company, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, New York Life, North American Company, OneAmerica, Principal National Life, Principal Life Insurance, Protective Life Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Savings Bank Life Insurance Company, Symetra, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, Voya Life Insurance Company, William Penn Life Insurance Company of New York

INFORMAL INQUIRY

COMPLETE ALL QUESTIONS AND DO NOT RETURN UNLESS AUTHORIZATION IS SIGNED

TO BE USED WHERE THERE IS A QUESTION OF INSURABILITY. THIS IS NOT AN APPLICATION FOR INSURANCE

PROPOSED INSURED (PRINT) Name:			ADDRESS
SS#:			City State Zip
Sex Date of Birth M_____ ___/___/___ F_____ mo.day.yr.	Hgt._____ Wgt_____	Birthplace	Beneficiary (give full name and relationship to insured)
Amount $_____	term_____ ordinary life_____ universal life____ variable _____		Have you used tobacco within the last 24 months? _____ yes _____ no
Describe nature of Underwriting concern _____ _____ _____ _____ _____ _____ _____			Occupation: (give name and address of employer or association and exact duties Is proposed insured, stockowner, owner, or principal? yes _____ no _____

Have you ever been rated or declined? _____yes _____ no If yes, give details below

Name of Company	Year	Rate	Reason

Insurance now inforce or applied for:

Name of Company	Amount	Yr. Issued	Plan

Applicant's Personal Physician:	Date of last consultation:_____
Address:	Reason:_____
Phone Number	Clinic ID#:_____

MEDICAL HISTORY

Illness/Treatment	Date	Name and address of doctor/hospital

If medical history involves cardiovascular issues, please indicate date of last EKG _____ By whom _____	Will the new insurance replace any inforce coverage? _____yes _____no

Broker (please print) _____ Phone #_____

Address _____