LifeEase
BRINGING SIMPLE TO LIFE™

# Authorization to Obtain, Release, and Disclose Information

Advisor's Choice
INSURANCE BROKERAGE SERVICES

I, an undersigned Proposed Insured, authorize Advisor's Choice Insurance Brokerage Services LLC, The Life Insurance Center, and/or their represented Insurance Companies to complete a Personal History Interview and to obtain an Investigative Consumer Report on me (and on my minor children if they are applying for insurance). Further, I authorize the release of any medical or non-medical information that relates to me (and on my minor children if they are applying for insurance) that is necessary for the insurance Companies to underwrite my application, to service the policy that may be issued in connection with the application or to determine my eligibility and/or the insurance carrier's obligations under the policy.

The medical and/or non-medical information shall include, but not be limited to: (1) past or current health conditions including illnesses, sicknesses, diseases, disabilities, disorders, accidents, injuries, and drug prescriptions; (2) confinements in any hospital, medical facility, VA facility or medical clinic; (3) outpatient treatment in any hospital, hospital emergency room, medical facility, VA facility or medical clinic; (4) treatment for alcohol abuse, drug abuse or mental health protected by Federal Law; (5) other life insurance policies or coverages which may be currently applied for or in force on my life or the lives of my minor children; (6) motor vehicle violations; and (7) financial information.

I authorize any person or organization that has such medical or non-medical information to release this information. This includes any doctor, medical professional, health practitioner, therapist, counselor, hospital, clinic or any other medically related facility, pharmacy, benefit manager, VA facility, or medical clinic, other insurance company, reinsurer, any company that evaluates a person's expected mortality or life expectancy, life settlement company, consumer reporting firm, employer, accountant, motor vehicle division or the Medical Information Bureau (MIB, Inc.). This information may be released to the Insurance Companies or their legal representative. However, I understand that the MIB, Inc. will release records of information only to the Insurance Companies.

I understand that the Insurance Companies may disclose the information in its file(s) to their reinsurer(s), the MIB, Inc., other insurance companies, other persons and /or organizations performing business functions on behalf of the Insurance Companies, or as required by law, including any mandated reporting to state agencies. I understand that I may request details about any of the information gathered about me or my minor children which relates to this application and that such requested information and the identity of the source of the information shall be released to me or in the case of medial information, to a licensed medical person of my choice.

I agree that a photocopy of this authorization is as valid as the original and understand that I may receive a copy of this authorization upon request. I also agree that this authorization shall be valid for thirty (30) months from the date shown below. This authorization may be revoked upon written request, except to the extent that action has already been taken. However, I understand that revocation may be a basis for denying my insurance application and/or coverage and benefits.

_____ _____/_____/_____

Signature of Proposed Insured/Patient or Personal Representative — Date

*(Parent or Guardian if under 15 years of age)*

For advisor use only.
The completed request can be emailed to LifeEase@myadvisorschoice.com
or fax to the LifeEase team at (805) 246-9233.

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# Authorization for Release of Health-Related Information

Advisor's Choice
INSURANCE BROKERAGE SERVICES

## This authorization complies with the HIPAA Privacy Rule.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other healthcare provider that has provided payment 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 personal health information concerning me to any carrier's agents, employees and representatives (collectively referred to as "The Companies"). 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 exclude psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a healthcare provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individuals medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization): medical prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct my Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment 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 Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, attention Privacy Official. I understand that revocation is not effective to the extent that any of my providers has relied on this authorization or to the extent that the companies 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 federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I sign this authorization. I further understand that if I refuse to sigh this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____/_____/_____

Print Name of Proposed Insured/Patient — Date of Birth

_____ _____/_____/_____

Signature of Proposed Insured/Patient or Personal Representative — Date

*(Parent or Guardian if under 15 years of age)*

_____

Description of Personal Representative's Authority or Relationship to Patient

*(for example, parent or guardian)*

Life Insurance Products:
- are not insured by the FDIC;
- are not insured by any federal agency; and
- are not guaranteed by, or obligations or deposits of, any bank or any affiliate, or credit union.

For advisor use only.
The completed request can be emailed to LifeEase@myadvisorschoice.com
or fax to the LifeEase team at (805) 246-9233.