1500 State Street, Second Floor, San Diego, CA 92101

HIPAA COMPLIANT AUTHORIZATION
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured/Patient (Please type or print) Date of Birth

_______________________________________ ____________________

First *MI* *Last* *Month/Day/Year*

I authorize any: person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle agency, employer, or any other person or institution to release to: each of the insurance companies listed below, as well as to their reinsurers, any insurance support organizations, and those persons authorized to represent them, and Advanced Planning Services, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputation, finances, occupation, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the insurers named below and their reinsurers will use this information to help determine my eligibility for insurance. The insurance agent may also use this information to help update and improve my insurance program.

I agree that the above named parties may also disclose my information to other insurers, reinsurers, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with the underwriting process, or as may be otherwise lawfully required.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by

providing written notification to Advanced Planning Services, Inc. at the above Service Office address. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Advanced Planning Services, Inc. except as authorized by me or as required by law.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the carriers listed below may not be able to review my medical file. I understand that any authorized representative or I will receive a copy of this authorization upon request.

_______________________________ _______________________________

Signature of proposed insured *Name of Proposed Insured*

_______________________________ _______________________________

Signature of additional proposed insured (if applicable) *Name of Additional Proposed Insured*

________________ __________ _______________________________

City *State* *Month / Day / Year*

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

Advanced Planning Services, Inc.
Allianz
American General Life Ins. Co.
American National
Assurity Life
Attending Physicians Statement
Aviva
AXA
Banner
EMSI
Genworth
Guardian Life Insurance Co.
Hartford Life Insurance Co.
ING
John Hancock Life Ins. Co.
John Hancock USA (ManuLife)
Life of Southwest
Lincoln Benefit Life
Lincoln Financial Group
Metropolitan Life Insurance Co.
Minnesota Life
National Life
National Western
New York Life
North American
Old Mutual
Phoenix Home Life
Principal Life
Prudential Life Ins. Co.
Sun Life of Canada
Transamerica
United of Omaha
West Coast Life