Authorization to Obtain Information/ Waiver and Acknowledgement

Authorization:

I Authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Level Four Insurance Services and its agents, employees, and representatives. 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My providers to release and disclose my entire medical record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so that Level Four Insurance services may: 1) underwrite my application for coverage by making eligibility, risk, rating, policy issuance and enrollment determinations; 2) obtain insurance: and 3) conduct other legally permissible activities that pertain to any coverage I have or have applied for with the Insurance Companies named below:

AIG Life	Lincoln National Life
Allianz	Met Life
American General	Mutual of Omaha
American National	NACOLAH
AVIVA	Nationwide
AXA Equitable	Principal Life
Genworth	Protective
Hartford	Prudential
ING ReliaStar	Royal Bank of Canada
ING Security Life of Denver	Sun Life of Canada
John Hancock	Transamerica
Life of Southwest	Union Central
Lincoln Benefit Life	West Coast Life

Other Insurance Company: ____

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 to Level Four Insurance Services. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality.

WAIVER AND ACKNOWLEDGEMENT:

This Waiver and Acknowledgement has been signed on the date set forth below by the undersigned in favor of Level Four Insurance Services, its successors, assigns, shareholders, directors and employees (collectively "Level Four").

Applicant acknowledges, understands and agrees as follows:

- That Applicant has filed an application with Level Four intending to secure life insurance from one or more insurance writers.
- That, in the course of applying for life insurance coverage, Level Four has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- That LFIS will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- That LFIS maintains an electronic data interchange through which certain Authorized underwriters and/or other insurance industry representatives may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those underwriters.
- That LFIS will use the interchange to store some or all of the confidential and personal information applicant has provided, and, therefore, that underwriters will be able to gain access to that information through the interchange.
- That the underwriters will gain access to the interchange via the internet or other, similar computer-based telecommunications systems.
- That, even though LFIS has in place security measures LFIS believes appropriate to protect the information from unauthorized access and use, and even though LFIS can make no guarantee as to the ability to protect information it contains from unauthorized access by hackers or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the information.
- That LFIS cannot control the use, dissemination, publishing or interpretation of the information contained in the information once gathered by an underwriter.
- That applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to applicant in LFIS possession and/or stored.
- That applicant will indemnify LFIS for all costs and expenses incurred by LFIS or any of its employees, directors or agents in enforcing this waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I **ACKNOWLEDGE** that I have received a copy of this document.
I **AGREE** this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: _______/________/_______

City:_____________________________ State:_________ Insured's DOB ___________________

Insured _________________________________ Insured's SSN __________________________
(Printed Name of Proposed Insured/Parent or Guardian)

X____ X_________________________________
(Signature of Proposed Insured/Parent or Guardian) (Signature of Witness)

Physician Information
(Required for all Informals)

1) Physician:_______________________________ **Phone:**_____________________

Address: __________________________________ **Fax:**_______________________

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2) Physician:_______________________________ **Phone:**_____________________

Address: __________________________________ **Fax:**_______________________

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3) Physician:_______________________________ **Phone:**_____________________

Address: __________________________________ **Fax:**_______________________

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4) Physician:_______________________________ **Phone:**_____________________

Address: __________________________________ **Fax:**_______________________

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