WARD BROKERAGE ASSOCIATES, LLC.

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(860) 761-3773 Fax (860) 394-4948
jon@wardbrokerage.com

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Applicant(s):_____

Companies:

Ward Brokerage Associates, LLC

Advanced Planning Services, Inc.
American General/ United States Life
Allianz Life Insurance Co. (Allianz Life Ins. Co. of NY)
American National
Aviva Life/Indianapolis Life (Aviva Life & Annuity of NY)
AXA-Equitable
Banner
Columbus Life
The Foresters
Genworth
The Hartford Life

Hooper Holmes, Inc.

ING
John Hancock
Lafayette Life
National Life of VT/Life Insurance Company of the Southwest
Lincoln Benefit
Lincoln National
Mass Mutual

MediConnect Global, Inc.

Met Life Investors/Metropolitan
Minnesota Life
Mutual of Omaha (Companion Life)
Nationwide
New York Life
North American
Old Mutual Life
Phoenix Life
Presidential Life
Principal National (Principal Life)
Protective/West Coast Life
Prudential

Rapid APS

Security Mutual Life
Sun Life

Tellus Brokerage Connections

Transamerica
UNIFI Companies (Union Central, Ameritas)

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 above, as well as to their reinsurers, any insurance support organizations, and those persons authorized to represent them, and Ward Brokerage Associates, LLC or Tellus Brokerage Connections; 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 above 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 Ward Brokerage Associates, LLC 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 Ward Brokerage Associates, LLC or Tellus Brokerage Connections 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.

This Authorization Signed at:

CITY:_____ STATE:_____ DATED:_____

PROPOSED INSURED SIGNATURE <1>:_____

PROPOSED INSURED SIGNATURE <2>:_____

AGENT SIGNATURE:_____