AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Authorization is HIPAA compliant

Proposed Insured: _____

Date of Birth: _____ Social Security#_____

PURPOSE

The purpose of this Authorization is to permit MVP Financial Services, Inc. to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institution ("the companies") listed below. Information that may be released to and disclosed by MVP Financial Services, Inc. and the Companies listed below pursuant to this Authorization shall include any and all information, to the extent permitted by applicable law.

COMPANIES: _____

Accordia Life, Advanced Settlements, AIG, Ashar Group, Assurity Life, Athene, AVIVA, AXA-Equitable, Allianz, American General Life Company, Banner Life (Legal & General Life), Coventry First, Fidelity Life, First Life Financial, Genworth Financial, Guarantee Trust Life, Illinois Mutual, Voya, John Hancock, Lincoln National Life Insurance Company, Mass Mutual, MetLife, Minnesota Life, Mutual of Omaha, National Life, North American Company for Life and Health, Principal Life, Protective, Prudential, The Standard Life, Transamerica Life Companies, State Life, United of Omaha, West Coast Life.

INFORMATION TO BE RELEASED FROM: _____

The information to be released pursuant to this Authorization includes any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or condition ("information"), to the extent permitted by law.

Specifically, information includes all information, records or data relation to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that this information may include results from blood, saliva, urine and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of: Alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; AIDS, HIV infection, including medical test results.

AUTHORIZATION

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information about me to release such information to MVP Financial Services, Inc., and its authorized representatives.

I specifically authorize the Companies listed above in this document to receive information from and to release information to MVP Financial Services, Inc. I also specifically authorize MVP Financial Services, Inc. and the companies listed above in this document to release information about me to their reinsures, underwriters or other persons or organizations performing business, professional, or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to release information directly to any Company listed above in this document, upon such insurer's request, provided the insurer is a member of MIB. *

I understand the Information disclosed to MVP Financial Services, Inc. may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to MVP Financial Services, Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, MVP Financial Services, Inc., or the listed Insurance Companies may not be able to process my request.

I also authorize my Agent, named below, to receive information and I authorize MVP Financial Services, Inc. to disclose such information to my Agent, to assist in the purpose of this Authorization to the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original. This Authorization shall be effective for one year (1 year) after the date signed below, unless revoked by me in writing and notice of the revocation is provided to MVP Financial Services, Inc, 1701 Lake Ave., Suite 215, Glenview, IL 60025.

Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

_____ _____

Proposed Insured's Signature (or that of Authorized Representative) Date

_____

Print Name of Proposed Insured

_____

If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

_____ _____

Print Name of Agent Phone Number or Email of Agent

DATE OF AUTHORIZATION EXPIRATION_____

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsures may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. If you contact MIB, Inc., P. O. Box 105, Essex Station, Boston, MA 02112 or call 1 (612) 426-3660.

Inquiry cannot be considered unless authorization is signed by Proposed Insured.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO GENERAL AGENT AND BROKER

Proposed Insured: _____

Date of Birth: _____ Carrier:_____ Policy #:_____

PURPOSE

It is my understanding that the purpose of this authorization is to facilitate use of this Information by the General Agency, **MVP Financial Services, Inc.**, or Broker, _____, or their authorized representatives to evaluate an application for insurance on my life. I understand that the carrier listed above assumes no liability with respect to any application for insurance to other carriers and makes no representation as to the completeness or accuracy of the Information. I also understand that the carrier listed above will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

COMPANIES AUTHORIZED TO RECEIVE THIS INFORMATION IF REQUESTED: _____

Accordia Life, Advanced Settlements, AIG, Ashar Group, Assurity Life, Athene, AVIVA, AXA-Equitable, Allianz, American General Life Company, Banner Life (Legal & General Life), Coventry First, Fidelity Life, First Life Financial, Genworth Financial, Guarantee Trust Life, Illinois Mutual, Voya, John Hancock, Lincoln National Life Insurance Company, Mass Mutual, MetLife, Minnesota Life, Mutual of Omaha, National Life, North American Company for Life and Health, Principal Life, Protective, Prudential, The Standard Life, Transamerica Life Companies, State Life, United of Omaha, West Coast Life.

INFORMATION TO BE RELEASED:

The information to be released pursuant to this Authorization includes any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or condition ("information"), to the extent permitted by law. Information includes but is not limited to the results of any physical examination or tests, electrocardiogram, chest X-ray, and Attending Physician Statements.

Specifically, information includes all information, records or data in relation to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that this information may include results from blood, saliva, urine and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of (initial those that apply: ___Alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); ___Serious communicable disease or infection, including sexually transmitted diseases; ___HIV infection, including medical test results.

AUTHORIZATION

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information about me to release such information to MVP Financial Services, Inc., and its authorized representatives.

I specifically authorize the specified Carrier listed above in this document to receive information from and to release information to MVP Financial Services, Inc. I also specifically authorize MVP Financial Services, Inc. and the companies listed above in this document to release information about me to their reinsurers, underwriters or other persons or organizations performing business, professional, or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to release information directly to any Company listed above in this document, upon such insurer's request, provided the insurer is a member of MIB. *

I understand the Information disclosed to MVP Financial Services, Inc. may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to MVP Financial Services, Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, MVP Financial Services, Inc., or the listed Insurance Companies may not be able to process my request.

I also authorize my Agent, named below, to receive information and I authorize MVP Financial Services, Inc. to disclose such information to my Agent, to assist in the purpose of this Authorization to the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original. This Authorization shall be effective for one year (1 year) after the date signed below, unless revoked by me in writing and notice of the revocation is provided to MVP Financial Services, Inc, 1701 Lake Ave., Suite 215, Glenview, IL 60025. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

_____

Proposed Insured's Signature (or that of Authorized Representative) Date

_____

Print Name of Proposed Insured

_____

If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

_____ _____

Print Name of Agent Phone Number or Email of Agent

DATE OF AUTHORIZATION EXPIRATION_____

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsures may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. If you contact MIB, Inc., P. O. Box 105, Essex Station, Boston, MA 02112 or call 1 (612) 426-3660.

Inquiry cannot be considered unless authorization is signed by Proposed Insured.

Authorization to Obtain and Disclose Confidential Information

Notice to Proposed Insured(s)

Instructions to Producer: This notice must be given to the proposed insured before or at time of signature

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

Medical Information Bureau

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

LEAVE WITH PROPOSED INSURED