

HIPAA FORM

19900 MacArthur Blvd, Ste 900, Irvine CA 92612

This is not an Application for Insurance

Agent's Name: _____ **E-Mail Address:** _____

Phone Number _____ **Fax Number** _____

Proposed Insured: _____ Sex: M F

Date of Birth: _____ **Social Security #** _____ **State of Residence:** _____

Plan of Insurance: WL UL Term _____ yr. Second to Die LTC Amount of Insurance being Requested? _____

Have you smoked cigarettes in the past 12 months? NO YES Have you smoked cigarettes in the past 36 months? YES NO

Have you ever used any other forms of tobacco products, such as the patch, gum, chewing tobacco, cigar, etc.? YES NO

If YES, describe use: _____

Authorization for Release of Health Related Information. This Authorization complies with the HIPAA Privacy Rule.

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 companies listed below, as well as to their reinsurers, any insurance support organizations, and those persons authorized to represent them, and SRBIS 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 my agent or advisor, the companies listed below, and their re-insurers will use this information to help determine my eligibility for insurance and they may discuss and disclose this information with each other in helping determine my eligibility. The agent or advisor 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 further authorize any person licensed to provide health care services, hospital, clinic, or other medical related facility, insurer, insurance support organization, the Medical Information Bureau Inc., consumer reporting agency, state motor vehicle agency, employer, or any other person or institution to discuss with Strategic Medical Consulting (SMC) and/or any of its representatives, matters concerning my medical treatment, condition, prognosis, prescriptions, medical information, and records.

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 SRBIS at the above 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 will not be disclosed except as provided in this agreement or 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 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 primary proposed insured X _____ / ____/____

- | | | | | |
|-------------------------------|----------------------------|-------------------|--------------------|------------------------|
| Allianz | Equitable | Legal & General | OneAmerica | Strategic Medical |
| American National | Exceptional Risk Advisors | Lincoln Financial | Pacific Life | Consulting, Inc. (SMC) |
| Ameritas | F&G | MassMutual | Penn Mutual | Symetra |
| Balanced Strategies, LLC | Financial Independence Grp | Mutual of Omaha | Principal | The Standard |
| BrightHouse Financial | Foresters Financial. | National Life/LSW | Protective | Transamerica |
| Columbus Life | Global Atlantic | Nationwide | Prudential | Zurich |
| Corebridge Financial | Guardian | New York Life | Sagicor Life | |
| Disability Insurance Services | John Hancock | North American | Securian Financial | |



Proposed Insured Name: _____ DOB _____

Has the Proposed Insured:			
<p>1. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Within the last 6 month*:</p> <ul style="list-style-type: none"> • been admitted to or treated at a hospital or other medical facility for more than 24 hours; or • been advised to be admitted to or treated at a hospital or other medical facility; or • had surgery performed or recommended; or • had an unintentional loss of 10 pounds or more of his/her body weights; or • had: <ul style="list-style-type: none"> ✓ any medical testing (excluding HIV testing); ✓ a medical evaluation by a health care provider; ✓ testing or evaluation recommended for which a final diagnosis has not been determined (excluding HIV testing)? <p>*excluding: pregnancy or childbirth; routine annual physicals where all results and tests were within normal limits; acute minor injuries like broken bones, sprains or cuts; acute seasonal illnesses like a flu, virus, allergies or colds; visits for prescription renewals.</p>		
<p>2.</p>	<p>Ever had or been treated for, or ever been (or currently are being evaluated for or advised to seek an evaluation for:</p> <table border="0"> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer • Kidney failure • Organ transplant • Cardiac arrest • Heart surgery • An implanted defibrillator </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> • Hepatitis C • Progressive muscular or neurologic disease • Alzheimer's disease or dementia • Stroke • Cardiomyopathy or congestive heart failure, or • Any lung or breathing disorder requiring oxygen </td> </tr> </table> <p>For each item checked, please provide dates, and, name and contact information for treating or recommending physician.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Cancer • Kidney failure • Organ transplant • Cardiac arrest • Heart surgery • An implanted defibrillator 	<ul style="list-style-type: none"> • Hepatitis C • Progressive muscular or neurologic disease • Alzheimer's disease or dementia • Stroke • Cardiomyopathy or congestive heart failure, or • Any lung or breathing disorder requiring oxygen
<ul style="list-style-type: none"> <input type="checkbox"/> Cancer • Kidney failure • Organ transplant • Cardiac arrest • Heart surgery • An implanted defibrillator 	<ul style="list-style-type: none"> • Hepatitis C • Progressive muscular or neurologic disease • Alzheimer's disease or dementia • Stroke • Cardiomyopathy or congestive heart failure, or • Any lung or breathing disorder requiring oxygen 		
<p>3.</p>	<p>Ever had, been treated for or had treatment recommended by a health care provider for:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Immune System Disease: <input type="checkbox"/> Human Immunodeficiency Virus (HIV) Infection: or <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS)? <p>For each item checked, please provide dates, and, name and contact information for treating or recommending physician.</p>		
<p>4. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Ever used tobacco or nicotine product in any form (including cigarettes, cigars, cigarillos, pipe, chewing tobacco, nicotine patches/gum/lozenges, or nicotine vaporizers (e-cigarettes)? If YES, give details of type of nicotine product, amount and frequency of use and date last used.</p>		



5. <input type="checkbox"/> Yes <input type="checkbox"/> No	In the last 5 years: <ul style="list-style-type: none">• been advise by a health care provider to cease or limit excessive alcohol consumption;• been treated or had treatment recommended for alcohol or drug abuse;• used any illegal drug or prescription drug that was not prescribed for you by a health care provider or used a drug prescribed to you other than as prescribed?
6. <input type="checkbox"/> Yes <input type="checkbox"/> No	Ever had an application for life insurance declined, postponed, rated substandard, or offered with a reduced face amount?
7. <input type="checkbox"/> Yes <input type="checkbox"/> No	Have any immediate family members (parents, brothers, sisters) die from coronary artery disease or cancer prior to age 60?
8. <input type="checkbox"/> Yes <input type="checkbox"/> No	Been cited for one or more moving violations with the last 2 years?
9. <input type="checkbox"/> Yes <input type="checkbox"/> No	Been cited for driving while intoxicated or while otherwise impaired?
10. <input type="checkbox"/> Yes <input type="checkbox"/> No	Been arrested, convicted, or imprisoned for a felony and/or currently awaiting trial for any crime and/or felony? If YES, give details of type, date, city/state of felony and /or crime and if currently on probation or parole.
Does (or has) Proposed Insured:	
11. <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan to travel outside the U.S. or Canada, or change country of residence in the next 2 years? If YES, give details of location (city/country), purpose, frequency and duration.
12. <input type="checkbox"/> Yes <input type="checkbox"/> No	Fly (or flown) as a student pilot, licensed pilot, or crew member in any aircraft including ultralight planes, or as a passenger in an ultralight plan in the last 2 years?
13. <input type="checkbox"/> Yes <input type="checkbox"/> No	Engage (or engaged) in any form of motor vehicle or power boat racing, sky diving/parachuting, skin or scuba diving, hang-gliding, mountaineering, rock climbing or any other hazardous activities in the last 2 years?



Information Regarding Last Medical Consultation

Proposed Insured:

a. Date of last visit to ANY doctor/physician

b. Reason for and outcome of visit
(Diagnosis / Treatment / Medication Prescribed)

c. Physician Name, Address and Phone Number

d. Provide Primary Physician name and contact information if different from Item #c.

e. Has your Primary Physician or a Specialist ever recommended tests or follow-up visits that you have not completed or scheduled? If yes, please provide the name of the recommending Physician, the approximate date the recommendation was made. When will these tests or follow-up visits be completed? (The insurance carrier will require all test results and information on follow-up visits or the underwriting process may not be completed.)