2900 Bristol St. Suite B300
Costa Mesa, CA 92626
949.955.0255 phone
949.955.9215 fax

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured(s)/Patient(s) (Please print)

First MI Last DOB Month/Day/Year

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insure, reinsurer, insurance support organization, the Medical Information Bureau, Inc. consumer report 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 reinsures, any insurance support organizations, and those person authorized to represent them; and BGA Insurance; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, 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.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

Accordia Life
Allianz
American General Life Ins.
American National
AXA
Banner Life
Columbus Life
Conseco
F & G
Genworth Financial Co.
Guardian Life Insurance Co.
Indianapolis Life
ING
Jackson National
John Hancock Life Ins. Co.
John Hancock USA
Kansas City Life
Life of Southwest
Lincoln Financial Group
Mass Mutual
MetLife
Metropolitan Life Insur. Co.
Minnesota Life
Mutual of Omaha
Mutual Trust Life
National Western
Nationwide
New York Life
North American
Ohio National Life
Old Mutual
One America
Pacific Life Insur. Co.
Penn Mutual
Petersen International
Principal Life Insurance Co.
Principal National Life
Protective Life
Prudential Life Ins. Co.
ReliaStar
Security Life of Denver
Security Mutual
Standard Life
LMSuperior Medical Group
Symetra
Tellus
Transamerica Life Insurance
Company Union Central
United of Omaha
US Life
VOYA
William Penn
Zurich

2900 Bristol St. Suite B300
Costa Mesa, CA 92626
949.955.0255 phone
949.955.9215 fax

Company

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 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 BGA Insurance 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 will not be re-disclosed by BGA Insurance 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 there under. I understand that my medical providers may not refuse treatment or payment of health care services regardless if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization for release of my complete medical records, the carriers listed above may not be able 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