

HIPAA Authorization for Release of Information
(HIPAA – Health Insurance Portability and Accountability Act)

I hereby authorize Brokers Clearing House, Ltd (“my Representative”) and affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years (“my Providers”) to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. 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 my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record with restriction to Brokers Clearing House, Ltd. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I also hereby authorize the companies listed below to disclose any and all medical information, which has been collected by such companies in connection with my current request for life insurance, to Brokers Clearing House, Ltd (“my Representative”). Such information includes, but is not limited to the results of any physical examination or tests, electrocardiogram, chest X-ray and Attending Physician Statements.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their reinsurers as well as Brokers Clearing House, Ltd. and its staff, employees and affiliated companies.

The records may be transmitted via U.S. regular mail, various overnight mail services, fax machines, and through the use of secured electronic devices.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization Brokers Clearing House, Ltd. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured’s Name _____ Proposed Insured’s Signature _____

Signed and Dated on _____ At _____
(City) (State) (Zip)

Agent/Witness _____

AllState/NY, Allianz Life, Allianz Life/NY, American General Life, American National, Assurity Life, Aviva, AXA Equitable Life Ins Co, Banner Life, Companion Life, Genworth Life Ins Co, Genworth Life Ins Co of NY, Genworth Life & Annuity Ins Co, ING USA Annuity and Life Ins Co, John Hancock USA, John Hancock of NY, Lincoln Benefit Life, Lincoln Financial Group, MetLife Investors USA, Metropolitan Life Insurance Company, Mutual of Omaha, Nationwide Life Ins Co, North American Co for Life & Health, Phoenix Life, Prudential Ins Co, Pruco Life Ins Co, Pruco Life Ins Co of NJ, ReliaStar Life Ins Co, ReliaStar/NY, Security Life of Denver, Sun Life, Transamerica, Union Central, United of Omaha, United States Life Insurance Co/NY, West Coast Life, William Penn Life/NY