AUTHORIZATION TO OBTAIN & DISCLOSE INFORMATION

Advantage Insurance Network
Allianz Life
Allianz Life of NY
America's Partners, LLC
American General
American National
AmerUs Life Ins.
Aviva Life
Aviva Life Ins. Of NY
AXA Equitable Life Ins. Co.
Banner Life
Conseco Ins. Co.
Coventry First
CPS Insurance
EquiTrust Life Ins.
Fidelity & Guaranty
Fidelity & Guaranty of NY
First Colony Life
First Penn-Pacific
General American
Gerber Life
Great American
Guardian Life
Hartford Life
ING Life Ins. & Annuity
Integrity Life
ING Life Ins. & Annuity
Integrity Life
John Hancock Life
John Hancock Life (USA)
John Hancock Life of NY
Kansas City Life
Lafayette Life
Liberty Life
Lincoln Benefit Life
Lincoln Life & Annuity Co. of NY
Lincoln National Life Ins. Co.
MassMutual
MetLife Invest USA
MetLife Investors
Metropolitan Life Ins. Co.
Midland National
Minnesota Life
Nationwide Life
New England Life Ins. Co.
New York Life
New York Life & Annuity
North American Co. for L&H NY
Ohio National Life Assurance
Ohio National Life Ins.
Pacific Life
Penn Mutual
Principal Life
Protective Life
Provident Life
Provident Life & Acc.
PRUCO Life Ins. Co.
PRUCO Life of NJ
Prudential Financial
Reliastar Life – ING
Reliastar Life of NY – ING
Security Benefit
Security Life of Denver – ING
Security Mutual of NY
Sequoia Premier Partners
Sun Life & Annuity
SunAmerica Life Ins.
The Producer's Network
Transamerica Financial Life
Transamerica Life
Transamerica Life & Annuity
Transamerica Occidental
Travelers Ins. Co.
Travelers Life & Annuity
Union Central
United of Omaha
West Coast Life
Western Reserve
William Penn of NY

The terms that follow have respective meaning when used in this Authorization.

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU: Medical Information Bureau, Inc.
AUTHORIZATIONS: Authorization to Obtain and Disclose Information

I understand that any Company named above, its re-insurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) re-insurer; (6) insurance support organizations; (7) financial source; and (8) employer, to furnish the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid at the original. To facilitate rapid submission of such information, I authorize all said sources, except Medical Information Bureau, Inc. to give such records or knowledge to the above mentioned.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; and (9) other personal traits.

The Companies named above and their re-insurers will use this information in order to determine whether I am insurable. The insurance agent may also use this information to help update and improve my insurance program.

Those parties named in the first paragraph of this Authorization may disclose the information that they have collected. They may disclose this information to (1) other insurers to which I have applied or may apply; (2) re-insurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be allowed by law.

A photographic copy of this Authorization and acknowledgment shall be as valid as the original. This Authorization will be valid for 30 Months after the date it is signed (two years in R.I.). I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). I understand that I or my authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

Signed at___________________________this_________________day of____________________, __________

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Name   Signature (Parent of proposed insured is a minor)   Date of Birth