Authorization for Release of Information

I hereby authorize **Global Insurance Solutions Group** ("my Representative") and its staff, affiliated companies, and/or entities, including but not limited to RSA Medical, insurance companies and their re-insurers, to possess, obtain and/or re-disclose my existing personal financial and health information. 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.

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 payment, 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, including but not limited to RSA Medical, insurance companies and their re-insurers. 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, my prescription records and history of medication prescribed, but excludes psychotherapy notes.

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 by **Global Insurance Solutions Group**, affiliated insurance companies and their re-insurers. The records may be transmitted via US regular mail, various overnight mail services and through the use of secured electronic devices.

By my signature below, I terminate any agreements I have made with my Providers to restrict any medical records and any associated HIPAA protected health information and I instruct my Providers to release and disclose my entire medical records without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer is covered by certain federal rules governing privacy and confidentiality of health information.

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 this authorization permits **Global Insurance Solutions Group** to disclose my existing personal financial and health information to all or any insurance company, including but not limited to the following companies:

Accordia Life	EMSI	Metropolitan Life	The Standard
Allianz	Express Imaging Service	Minnesota Life	SBLI
American Equity	Gen Re	National Western Life	State Life
American Fidelity	Genworth Financial	National Life Group	Sun Life
American General	Guardian	Nationwide	Symetra
American National	IBU Inc.	New York Life	Transamerica
Assurity	John Hancock	North American Life & Health	US Life of NY
Athene	Lincoln Benefit Life	Pan American Life Ins Group	United of Omaha
AXA	Lincoln Financial	Penn Mutual	VOYA
Banner Life	LTCI Partners	Principal Financial	William Penn of NY
Companion Life	Manulife Bermuda	Principal National	
Columbus Life	Mass Mutual	Protective Life	
Credit Suisse	Mediconnect	Prudential	

I understand that I may write 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 My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.
I understand that if I refuse to sign this authorization, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments.

_____	_____
Proposed Insured's Name	Proposed Insured's Signature
_____	_____
Proposed Insured's Date of Birth	Proposed Insured's Social Security Number
_____	_____
Agent/Witness Signature	Date

Affiliated companies will treat the information regarding your insurability as confidential. They and their reinsurers may, however, make a brief report to the Medical Information Bureau, Inc. (MIB). MIB is a non-profit membership organization of life insurance companies. It operates an informational exchange bureau on behalf of its members. If you apply to another member company for life, health, or disability insurance, or a claim for benefits is submitted to such a company, MIB, upon request, will supply that company with any information it may have in its file.
Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in that file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The phone number is (617) 426-3660.
The companies and their reinsurers may also release information in their files to other insurance companies to whom you may apply for life, health, or disability insurance or to whom a claim for benefits may be submitted.

Global Insurance Solutions Group