

I, _____ authorize any life, health, annuity or disability insurance company, their reinsurers, Insurance Support Organizations such as Medical Information Bureau, Inc. and/or Consumer Reporting Agency, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Level Four Insurance Agency and its employees and those persons or entities providing services to Level Four Insurance Agency. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted disease. 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 that 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, life, health, annuity or disability insurance company or other health care provider to release and disclose my entire medical record without restriction.

The protected health information is to be disclosed under this authorization so that Level Four Insurance Agency may:

- 1) assist in the underwriting of my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
- 2) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance companies named below.

Accordia/Global Atlantic	AXA-Equitable	Nationwide	PRUCO Life Insurance Co
Advantage Insurance	Baltimore Life	New York Life	Sagicor
Network (AIN)	Cincinnati Life	North American	Symetra
Allianz	Foresters	Pacific Life	Transamerica
American General	John Hancock	Penn Mutual	United of Omaha
American National	Life of the Southwest	Principal Life	Zurich
Ameritas	Lincoln National	Principal National Life	Other: _____
Assurity	Minnesota Life/Securian	Protective	

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Level Four Insurance Agency, 12400 Coit Road, Suite 700 Dallas, TX 75251. I understand that a revocation is not effective to the extent that any of My Providers has relied on this authorization or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to their authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical records, Level Four Insurance Agency may not be able to process my application. I acknowledge that I will receive a copy of this authorization upon my request.

Printed Name of Proposed Insured

Date of Birth of Proposed Insured

Signature of Proposed Insured or Personal Representative

Date

Description of Personal Representative's Authority/Relationship to Proposed Insured