



Special Service Agency, Inc.
7110 Forest Ave.
Suite 102
Richmond, VA 23226

Financial and Medical Records Authorization

(This authorization complies with the HIPAA Privacy Rule)

Give completed and signed copy to Proposed Insured

Name of Proposed Insured/Patient (please print) _____
Date of Birth _____ S.S.# _____
Name of Additional Proposed Insured/Patient (please print) _____
Date of Birth _____ S.S.# _____

The purpose of this Authorization is to permit Special Service Agency to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, or health care provider that has provided treatment for 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 Special Service Agency and its staff, affiliated companies and/or entities, 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, 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 without restriction.

I understand that the information contained in these records 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. In connection therewith, I specifically authorize the companies listed below to receive information from, and to release information to, Special Service Agency. I also specifically authorize Special Service Agency and the companies listed below to release information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them.

This authorization shall be effective for twelve months after the date signed below. I understand that I am entitled to receive a copy of this authorization. I understand that I can revoke this authorization by sending written notice of the revocation to Special Service Agency, 7110 Forest Ave., Suite 102, Richmond, VA 23226 and that revocation will take effect when received by Special Service Agency. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid. I understand that any information that is used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by certain state and federal rules governing privacy and confidentiality of health information.

I acknowledge that I have read and understand the above authorization. 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 further agree that a copy of this authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Special Service Agency and/or any third party designation herein.

Signature of Proposed Insured/ Patient or Personal Representative _____ Date _____

Signature of Additional Proposed Insured/Patient or Personal Representative _____ Date _____

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient: _____

Name of Agent/Broker _____ S.S.# _____

Signature _____ Date _____

Companies to Which this Authorization Applies:

- | | | | |
|------------------------------|---------------------------|----------------------------|---------------------------------|
| Aviva Life and Annuity | American General Life Co. | Allianz Life Insurance Co. | American National Insurance Co. |
| Assurity Life Ins. Co. | AXA/Equitable | Banner Life | BRAMCO |
| Fidelity Life Insurance | Genworth Financial Co's. | Great American Life | Illinois Mutual |
| ING/ReliaStar | ING/USA | John Hancock Life | John Hancock Life (USA) |
| Lincoln Benefit Life | Lincoln Financial Group | Med America | MetLife |
| Met Life Investors | Mutual of Omaha | Nationwide | Principal Life |
| Principal National | Prudential | RSA Medical | Settlers Life |
| Special Service Agency, Inc. | Sun Life of Canada | Transamerica Life | Union Central Life |
| United Home Life | United of Omaha | West Coast Life | |

COLLECTION OF INFORMATION

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we received from you on applications, new account forms and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties, including, but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

DISCLOSURE OF INFORMATION

We will not share nonpublic personal information concerning our potential, current or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law.

Generally, we may disclose customer nonpublic information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your account;

- Your agent or broker/dealer
- Clearing agencies through whom we clear and settle securities transactions
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, such as banks and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information.

PROTECTION OF INFORMATION

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Special Service Agency, your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.