Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

This is not an application for insurance. No insurance will be issued as a result of the completion of this form.

_____ _____ / _____ / _____

Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsurance company, medical practitioner, medical facility or medical related facility, health information exchange, electronic health record provider, insurance laboratory, (Clinical Reference Laboratory, ExamOne Laboratory), consumer reporting agency, applicable state Motor Vehicle Departments, public records holder, Medical Information Bureau, financial professionals, or employer or other provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my medical record and any other information that may be considered protected information, including information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Protected health information includes: my entire medical record or medical history, which specifically includes any information regarding the diagnosis or treatment of mental illness/psychiatric health (excluding psychotherapy notes), use or abuse of tobacco, alcohol, or drugs, prescription history/pharmaceutical records, HIV/AIDS, sexually transmitted diseases, and genetic information, motor vehicle records, other insurance application activity, disclosures from financial professionals, and test results (to the extent permitted by law). This information can be concerning me or my minor children and can be released to any of the following entities (the "Insurance Companies"), their subsidiaries or reinsurer(s), or their legal representative:

M Financial Holdings Incorporated, its subsidiaries or reinsurer(s); First American Insurance Underwriters (FAIU); the following insurance companies, their subsidiaries or reinsurer(s) – Accordia, Allianz, Allstate, American General Life / AIG; American National, Ashar Group, AVIVA Life Insurance Company, AVS LLC, AXA Equitable Life Insurance Company, Banner Life, Cincinnati Life, Companion of NY, Coventry, Credit Suisse, Crump Insurance Services, Empire General, Gentry Partners, Genworth Life, Genworth Life Insurance Company of NY, Goldman Sachs Group, Guardian Life Insurance Company, Exceptional Risk Advisors, Hartford Life, Illinois Mutual, Independent Funding LLC, Indianapolis Life, Jackson National Life Insurance Company, John Hancock Life Insurance Company, Lifeline, Life Options, Life Settlement Solutions, Lincoln Benefit Life Company, The Lincoln National Life Insurance Company, M Financial Re, Manulife Financial, Mass Mutual Life Insurance Company, MetLife Insurance Company, Midland National Life Insurance Company, Minnesota Life Insurance Company, Mutual of Omaha, National Life, Nationwide Financial, Nationwide Provident, New York Life, North American Life & Health, Ohio National Life Insurance Company, Old Line Life, Pacific Life Insurance Company, Pan-American Assurance Company, Pan-American Life Insurance Company, The Penn Mutual Life Insurance Company, The Penn Insurance and Annuity Company, The Penn Insurance and Annuity Company of New York, Phoenix Life, Principal Life Insurance Company, Principal National Life Insurance Company, Premier Brokerage, Protective Life, Protective Life & Annuity of NY, Prudential Insurance Company of America, Pruco Life Insurance Company, ReliaStar Life Insurance Company, ReliaStar of New York, Securian Life Insurance Company, Security Life of Denver Insurance Company, Standard Insurance Company, Sun Life, Symetra Life Insurance, TIAA-CREF Life Insurance Company, Transamerica Life Insurance Company/ TLIC, Trinity Financial, Union Central, United of Omaha, United States Life Insurance of NY, UNUM Life Insurance Company of America, Voya, Welcome Funds, Inc., West Coast Life, William Penn Insurance Company of NY, Zurich America Life Insurance Company, PNC Wealth Management, and Heirmark, a Member Firm of M Financial Group. I further authorize the Insurance Companies to disclose my protected health information to third party service providers that assist in the underwriting and/or placement of insurance coverage.

I understand that the Insurance Companies have requested that I provide a blood, urine/and or oral fluid specimen(s) for testing by a licensed laboratory to assist in determining my insurability and that I will be provided information regarding the collection of such specimens prior to collection, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. I also understand that additional lab tests to be performed on my specimen(s) may include, but are not limited to, determinations of blood cholesterol and related lipids, screening for liver or kidney disorders, diabetes, hepatitis, immune disorders, Prostate Specific Antigen testing (a test for disorders of the prostate including prostate cancer), the presence of nicotine (cotinine), certain prescription medications, and drugs of abuse. Other tests may be performed on the specimen(s) as directed by the Insurance Company(ies).

By my signature below, I terminate any agreements I have made with My Providers to restrict my medical records and any associated HIPAA protected health information and I instruct My Providers to release and disclose my entire medical record without restriction. Protected health information is to be disclosed under this Authorization so that the Insurance Companies may determine whether they might consider offering me insurance coverage or benefits and for purposes of insurance underwriting, underwriting consultation, or auditing of underwriting. I understand that no insurance will be issued except on the basis of a signed, completed application of the respective Insurance Company. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My health care provider may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize my health care provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about the disclosure of my health information, I can contact my health care provider.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Heirmark at 7005 S. Edgerton Rd., Ste. 101, Cleveland, OH 44141 or to the medical records/health information department at My Providers and/or to The Insurance Companies listed above. I understand that such revocation will be effective as to each of My Providers when it is received by the Provider. I understand that a revocation is not effective to the extent that any of My Providers and/or the Insurance Companies have already relied on this authorization to disclose or use protected health information about me. 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 understand that if I refuse to sign this authorization, medical providers may not perform tests requested by the Insurance Companies which may not be able to determine whether they might consider offering me insurance coverage or benefits. Therefore, signing this authorization is a condition to medical providers performing those services. I agree that a copy of this authorization shall be as valid as the original.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

X

_____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

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

Authorization for Release of Health-Related Information

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THIS IS NOT AN APPLICATION FOR INSURANCE. NO INSURANCE WILL BE ISSUED AS A RESULT OF THE COMPLETION OF THIS FORM.

Name of Proposed Insured/Patient (Please Print) **Date of Birth**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, insurance or reinsurance company, medical practitioner, medical facility, health information exchange, electronic health record provider, 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 protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me or my minor children to Heirmark, Ltd [a Member Firm of M Financial Holdings Incorporated], and any of the following entities (the "Insurance Companies"), their subsidiaries or reinsurer(s), or their legal representatives: John Hancock Life Insurance Company, The Lincoln National Life Insurance Company, M Financial Holdings Incorporated, M Financial Re, Manulife Financial, Nationwide Life and Annuity Insurance Company, Pacific Life & Annuity Company, Pacific Life Insurance Company, Pan-American Assurance Company, Pan-American Life Insurance Company, The Penn Mutual Life Insurance Company, The Penn Insurance and Annuity Company, The Penn Insurance and Annuity Company of New York, Principal Life Insurance Company, Protective Life Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Symetra Life Insurance, TIAA-CREF Life Insurance Company and UNUM Life Insurance Company of America. I authorize MIB, LLC., and any MIB member insurer, to provide any medical or personal information that it has about me to M Financial Re. I further authorize the disclosure of my protected health information to MIB, LLC., and other third-party service providers that assist in the underwriting and/or placement of insurance coverage.

Protected health information includes: my entire medical record or medical history, which specifically includes any information regarding the diagnosis or treatment of mental illness (excluding psychotherapy notes), use or abuse of tobacco, alcohol, or drugs, prescription history, HIV/AIDS, sexually transmitted diseases, and genetic information and test results (to the extent permitted by law).

Protected health information is to be disclosed under this Authorization so that the Insurance Companies may determine whether they might consider offering me insurance coverage or benefits, or for purposes of insurance underwriting, underwriting consultation, or auditing of underwriting. I understand that no insurance will be issued except on the basis of a signed, completed application of the respective Insurance Company. This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing at any time, by sending a written request or revocation to the medical records/health information department at My Providers and/or to The Insurance Companies at their addresses listed on the attached page, and that such revocation will be effective as to each of My Providers when it is received by the Provider. I understand that a revocation is not effective to the extent that any of My Providers and/or the Insurance Companies have already relied on this authorization to disclose or use protected health information about me. 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 understand that if I refuse to sign this authorization the Insurance Companies may not be able to determine whether they might consider offering me insurance coverage or benefits. I acknowledge that I have received a copy of this authorization. I understand that a copy of this authorization shall be as valid as the original. Pre-Notice of Procedures as Required by The Fair Credit Reporting Act: This notice is to inform you that as part of our normal underwriting procedures in connection with an application for insurance.

An investigative consumer report may be made whereby information is obtained through public records searches.

X

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

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

Reset Form

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

THIS NOTICE DESCRIBES THE TYPES AND SOURCES OF INFORMATION THAT MAY BE COLLECTED AND USED IN UNDERWRITING AND AUTHORIZES THE PROCUREMENT OF NONMEDICAL INFORMATION INCLUDING CONSUMER REPORTS

In order to facilitate underwriting on your behalf, M Financial, its affiliates, agents, and any insurance support organization, carrier, or reinsurer acting on its behalf may obtain personal information about you from a variety of sources, including consumer reports. This includes, but is not limited to:

- Motor Vehicle Records
- Public Records
- Other insurance application activity (MIB, Inc.)
- Pharmaceutical Records
- Medical Records
- Disclosures made by you or your authorized representatives, which may include financial professionals, attorneys, trustees, family members, or other similar persons or organizations.

We understand that this information about you is personal. We are committed to protecting information about you and use all sources of data in compliance with relevant laws, including the Fair Credit Reporting Act (FCRA) and the Health Insurance Portability and Accountability Act (HIPAA).

By signing below, you acknowledge that you have reviewed the information above and authorize M Financial, its affiliates, agents, and any insurance support organization, carrier, or reinsurer acting on its behalf to procure nonmedical information including consumer reports on you for the underwriting purposes outlined above. Medical information, including pharmaceutical or medical records, will not be procured without your signature on an additional, HIPAA compliant authorization.

Signature: X_____ Date: _____

Addresses for the Insurance Companies

John Hancock Life Insurance Company U.S.A.
Life New Business 30
Dan Rd, Suite 55765
Canton, MA 02021-2809

The Lincoln National Life Insurance Company
Life Service Office
PO Box 21008
Greensboro, NC 27420-1008

The Lincoln National Life Insurance Company
Annuity Service Office
PO Box 2348
Fort Wayne, IN 46801-2348

M Financial Holdings Incorporated
1125 NW Couch Street, Suite 900
Portland, OR 97209

Manulife Financial
200 Floor St. E.
Toronto, Ontario M4W 1E5
Canada

Nationwide Life and Annuity Insurance Company
PO BOX 182928
Columbus, OH 43128-2928

Pacific Life & Annuity Company Life Insurance Division
P.O. Box 2030
Omaha, NE 68103-2030

Pacific Life Insurance Company Life Insurance Division
PO Box 2030
Omaha, NE 68103-2030

Pan-American Assurance Company, PanAmerican Life Insurance Company
601 Poydras Street
New Orleans, LA 70130

The Penn Mutual Life Insurance Company
600 Dresher Road
Horsham, PA 19044

The Penn Insurance and Annuity Company
600 Dresher Road
Horsham, PA 19044

Penn Insurance and Annuity Company of New York
PO Box 50001
Woburn, MA 01815

Principal Life Insurance Company
711 High St.
Des Moines, IA 50392

Protective Life Insurance Company
2801 US Highway 280S
Birmingham, AL 35223

Prudential Insurance Company of America, Pruco Life Insurance Company
Customer Service Office
2101 Welsh Road
Dresher, PA 19025-1406

Symetra Life Insurance
PO Box 549291
Waltham, MA 02454-9291

TIAA-CREF Life Insurance Company
Attention: Privacy Official 8500 Andrew Carnegie Boulevard Charlotte, NC 28262-8500

UNUM Life Insurance Company of America
One Fountain Square
Chattanooga, TN 37402