



HIPAA Authorization
Life New Business

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

I hereby authorize all of the people and organizations listed below to give Midwest Financial Network, AIG/American General Life Insurance Company, AVIVA, AXA, Banner, Cincinnati Life, Foresters, Genworth, The Hartford, ING, Jetstream Copy Service, John Hancock/Manulife, Lincoln Benefit Life, Lincoln Financial, ManageAbility, MetLife, Old Mutual, Phoenix, Principal Financial, Prudential, Sun Life, TransAmerica, Travelers, Union Central, Welcome Funds, West Coast Life, Western Reserve Life or specified entity _____ (collectively, the "Recipients") the following information:

- Any and all information relating to my health and my insurance policies and claims, including but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV and AIDS.
- **Excluding psychotherapy notes unless signed here by the insured** _____

I hereby authorize each of the following entities to provide the information outlined above:

- Any physician or medical practitioner;
- Any hospital, clinic or other health care facility
- Any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage).
- Any consumer reporting agency or insurance support organization;
- My employer, group policy holder, or group benefit plan administrator; and
- The Medical Information Bureau (MIB)
- The specific entity listed here: _____

I understand that the information obtained will be used by the Recipient to:

- Determine my eligibility for insurance;
- Underwrite my application for insurance;
- Determine my eligibility for benefits under any temporary insurance; and
- If a policy is used, determine my eligibility for benefits and contestability of the policy.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: Midwest Financial Network, 39500 High Pointe Blvd, Suite 400, Novi, MI 48375. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application. This authorization will be valid for 12 months. A copy of this authorization will be valid as the original. I understand that I am entitled to receive a copy of this authorization.

Name of Proposed Insured

Date of Birth

Signature of Proposed Insured

Date