



AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance companies listed below, their reinsurers, any insurance support organizations and the authorized representatives of those companies may need to collect information on me in regard to proposed coverage. Therefore, on the basis of this, or the attached Authorization for Release of Information Form, as needed I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to AdvisorNet Insurance and the insurance companies named below the types of information specified in this authorization upon presentation of this authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc. to give such records or knowledge to AdvisorNet Insurance.

The types of information will include records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal traits. The information will be used by the insurance companies named below and their reinsurers to determine eligibility of insurance, claims and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, I or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This authorization will be valid for two years after the date of signing. I understand I or my authorized representative has the right to receive a copy of this authorization. I acknowledge receipt of the attached Notice To Proposed Insured and Notice of Information Practices.

Signed at _____ on _____

Signature of Proposed Insured: _____

We Represent:

<i>Advantage Insurance Network</i>	<i>IBU</i>	<i>Principal</i>
<i>American General</i>	<i>Illinois Mutual</i>	<i>Prudential Financial</i>
<i>American National</i>	<i>ING-Reliastar Life</i>	<i>Secura DI</i>
<i>Aviva</i>	<i>John Hancock</i>	<i>Security Life of Denver</i>
<i>AXA</i>	<i>Lincoln Benefit</i>	<i>Standard</i>
<i>Banner</i>	<i>Lincoln Financial</i>	<i>Sun Life</i>
<i>Cincinnati Life</i>	<i>LTCI Partners</i>	<i>Summit Alliance</i>
<i>Crump</i>	<i>Mass Mutual</i>	<i>Transamerica Life Insurance Company</i>
<i>Financial Independence Group</i>	<i>MetLife</i>	<i>West Coast Life</i>
<i>Genworth Life & Annuity</i>	<i>Pacific Life</i>	<i>What Matters For Life, LLC</i>
<i>Guardian Insurance</i>	<i>Phoenix Insurance</i>	

NOTICE TO PROPOSED INSURED

In connection with your informal inquiry or application about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of The Bureau's information office is P. O. Box 105, Essex Station, Boston, Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this notice or their reinsurers may also release information in their files to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others such as medical professionals who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of the listed insurance companies and your agent's information practices. If you would like to receive a more detailed explanation of those practices, please send your written request to AdvisorNet Insurance

We Represent:

<i>Advantage Insurance Network</i>	<i>IBU</i>	<i>Principal</i>
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<i>American National</i>	<i>ING-Reliastar Life</i>	<i>Secura DI</i>
<i>Aviva</i>	<i>John Hancock</i>	<i>Security Life of Denver</i>
<i>AXA</i>	<i>Lincoln Benefit</i>	<i>Standard</i>
<i>Banner</i>	<i>Lincoln Financial</i>	<i>Sun Life</i>
<i>Cincinnati Life</i>	<i>LTCl Partners</i>	<i>Summit Alliance</i>
<i>Crump</i>	<i>Mass Mutual</i>	<i>Transamerica Life Insurance Company</i>
<i>Financial Independence Group</i>	<i>MetLife</i>	<i>West Coast Life</i>
<i>Genworth Life & Annuity</i>	<i>Pacific Life</i>	<i>What Matters For Life, LLC</i>
<i>Guardian Insurance</i>	<i>Phoenix Insurance</i>	

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

(PRINT name of patient) Birthdate _____ SS# _____

Information to be released from: _____
Name of designated Facility of Provider

Address

Information to be sent to: _____
Name of designated Recipient

Address

City, State, Zip Code Telephone Number _____

Information to be released:

- The most recent five years of patient records (chart notes, labs, x-rays, and special tests).
- Specific information (please specify): _____

Purpose for which disclosure is being made: (Please check one of the following)

- Insurance Attorney Doctor Personal

Patient Authorization

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

_____ Drug/alcohol abuse/treatment & diagnosis _____ Sexually transmitted disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental illness or psychiatric diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws. A photocopy of this authorization will be treated in the same manner as the original.

SIGNATURE: _____ DATE: _____
(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of the patient.]

This authorization will expire 180 days from the date signed.