Authorization Form and Questionnaire for the Impaired Risk Situation

(This Authorization complies with the HIPAA Privacy Rule)

Personal Information

Name:_____ Height: _____
SS #: _____ Weight:_____
DOB:_____ Income:_____
Phone Number:_____ Occupation:_____
Address:_____ Net Worth:_____
_____ , ____ _____

Medical Information:

A: Primary Care Physician's Contact Info (name, address, phone number):

Name: _____Phone:_____Date last seen: _____
Address:_____Reason: _____

B: Contact Info for any\all other Specialists and\or Doctors seen in the past 5 years:

1. Name: _____Phone:_____Date last seen: _____
   Address:_____Reason: _____
2. Name: _____Phone:_____Date last seen: _____
   Address:_____Reason: _____

C: List all conditions, sicknesses, Treatments and Medications prescribed: Be Specific. (The more information disclosed here, the greater the chance for an efficient and accurate underwriting opinion.):

I hereby authorize any heath plan, hospital, physician, medical practitioner, clinic, other medical or medically related facility, laboratory, insurance or reinsuring company, the medical information bureau Inc., consumer reporting agency, employer or the veterans administration, having information available as to diagnosis, treatment and prognosis with the respect to any physical or mental condition and/or treatment, including psychiatric conditions, drug or alcohol abuse, and any treatment and other medical or non-medical information about me or my health to give to the below marked companies or its legal representative, any and all such information.

To facilitate rapid submission of such information, I authorize all said sources, except MIB to give such records or knowledge to any agency employed by the company to collect and transmit such information.

I understand the information obtained by use of this authorization will be issued by the below marked insurance company and/or companies to determine eligibility for insurance. Any information obtained will not be released by the company to any person or organization except reinsuring companies, the medical information Bureau Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I understand that I may request to receive a copy of this authorization
I agree that a photographic copy of this authorization shall be valid as the original
I acknowledge having received and read the notice to the proposed insured and the medical information bureau notice.
I agree that this authorization shall remain valid for two years from this date.
I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification.

EIB, Inc. represents the following companies:

Allianz	EIB Inc.	Lincoln Life and	Phoenix Life	Transamerica
American	First MetLife Investors	Annuity of NY	Principal Financial	Unifi Companies
General Life\AIG	Guardian Life	Mass Mutual	Principal National	Union Central Life
American National Life	General American	MetLife Investors USA	Protective Life	United of Omaha
Ameritas	Hartford Life	Metropolitan Life	Prudential Financial	US Life of NY
Aviva Life	ING\ReliaStar	Mutual of Omaha	Security Mutual	West Coast Life
AXA (Equitable)	John Hancock	New York Life	Strategic Medical	William Penn
Banner Life	Lincoln Benefit Life	Pacific Life	Consulting, Inc.	List Other Name
Companion	Lincoln Financial	Penn Mutual	Sun Life	_____

_____ _____ _____ _____
Signature of Insured | Signature of Agent | Print Name of Agent | Date