# 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:_____
Address:_____ Occupation:_____
_____, _____ _____ 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: _____

I hereby authorize any heath plan, hospital, physician, pharmacy benefits manager, medical practitioner, clinic, other medical or medically related facility, laboratory, insurance or reinsuring company, the medical information bureau Inc., consumer reporting agency, 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.

I understand that the medical information released by this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse sexually transmitted diseases, AIDS, HIV or ARC and my past medical history including pharmaceutical/prescription records, drugs and diagnostic testing."

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 and there is a possibility of re-disclosure of any information disclosed pursuant to this authorization. That information once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

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:

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| Accordia Life | Guardian Life | MetLife Investors USA | Phoenix Life | Union Central Life |
| American General | General American | Metropolitan Life | Principal Life Insurance | United of Omaha |
| American National Life | Global Atlantic | Mutual of Omaha | Principal National Life | US Life of NY |
| Ameritas | Hartford Life | National Life Group | Protective Life | Voya Financial |
| Equitable | John Hancock | Nationwide | Prudential Financial | William Penn |
| Banner Life | Life of the Southwest | New York Life | Sagicor | Zurich |
| Brighthouse Financial | Lincoln Financial | North American | Security Mutual | |
| Companion | Lincoln Life and | Pacific Life | Sun Life | |
| EIB Inc. | Annuity of NY | Penn Mutual | Symetra | |
| Foresters | Mass Mutual | The PIA-NY | Transamerica | |

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