# 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: _____

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, 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 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 | EIB Inc. | Lincoln Life and | North American | Security Mutual |
| AIN | Equitable | Annuity of NY | Pacific Life | Sun Life |
| American General | F&G | Mass Mutual | Penn Mutual | Symetra |
| American National Life | Global Atlantic | MetLife Investors USA | PIA of NY | Transamerica |
| Ameritas | Guardian Life | Metropolitan Life | Phoenix Life | United of Omaha |
| Athene | Hartford Life | Minnesota Life | Principal Life Insurance | US Life of NY |
| Banner Life | John Hancock | Mutual of Omaha | Principal National Life | Voya Financial |
| Brighthouse Financial | Life of the Southwest | National Life Group | Protective Life | William Penn |
| Columbus Life | Lincoln Financial | Nationwide | Prudential Financial | |
| Companion | | New York Life | Securian | |

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