CONTINENTAL SOUTHERN
INSURANCE AGENCY, INC

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Continental Southern Insurance Agency, Inc., and its staff, affiliated agencies and/or entities, insurance companies and their re-insurers, hereby referred to as "my Representative," to disclose my personal financial and health information to the insurance companies listed below.

I authorize any life insurance company or any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, the Department of Motor Vehicles, or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies, and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases and prescriptions records, motor vehicle records, and history of medications prescribed. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Continental Southern Insurance Agency, Inc. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may by used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement of life, health, long term care, and other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their reinsurers as well as Continental Southern Insurance Agency, Inc., and its staff, employees and affiliated companies.

The records may be transmitted via U. S. regular mail, various overnight mail services and through the use of secured electronic devices.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write my Representative to revoke this authorization and the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Continental Southern Insurance Agency, Inc., may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Name _____ **Proposed Insured's Signature** _____

Signed and Dated On _____ **At (City, State, Zip Code)** _____

Agent/Witness _____

Accordia/Global Atlantic/Forethought
Allianz
American General/United States Life/Western National
American National
Assurity
Athene
AXA/Equitable
Banner/William Penn
Gerber
Great American
Integrity
John Hancock
Lincoln National
Mass Mutual
Minnesota Life/Securian
Nationwide
National Guardian
North American
Oceanview
OneAmerica/State Life
Pacific Life
Principal
Protective
Prudential
Sagicor
Symetra
Transamerica
United of Omaha/Mutual of Omaha