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| American General | Nationwide |
| American National | North American Company for Life & Health |
| AVIVA Life Insurance Co. | North American Company for Life & Health NY |
| AXA Equitable Life Insurance | Pacific Life |
| Banner Life Insurance | Protective Life |
| Canada Life Insurance Company | Protective Life of NY |
| Canada Life Insurance Company of NY | Pruco Life Insurance |
| First Metlife | Prudential Insurance Company of American |
| Genworth Life Insurance Co | Principal Life Group |
| Genworth Life Insurance Co of NY | Principal National Life Insurance Co |
| ING Companies | Reliastar Life (ING) |
| John Hancock USA / John Hancock Life | Reliastar Life of NY (ING) |
| John Hancock NY | Security Life of Denver (ING) |
| Life of the Southwest | Sun Life |
| Lincoln Life and Lincoln Life of NY | Transamerica |
| Lincoln National | United of Omaha |
| Mass Mutual | West Coast Life |
| Metlife Investors | William Penn Life Insurance |
| Minnesota Life | Universal Underwriters Life Insurance Company (Zurich) |

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided treatment or services to me or on my behalf (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Millennium Brokerage Group (the Company), its affiliates or providers and the life insurance companies listed above and their reinsurance companies. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may : 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4)administer coverage and 5)conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to the Company at 611 Commerce St, #2704, Nashville TN 37203. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application or inquiry. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of proposed insured/patient or personal representative

Date

Description of personal representative's authority or relationship to proposed insured/patient