AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ authorize any life, health, annuity or disability insurance company, their reinsurers, Insurance Support Organizations such as Medical Information Bureau, Inc. and/or Consumer Reporting Agency, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to The Insurance Group and its employees and those persons or entities providing services to the Insurance Group. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted disease. 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 that I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, life, health, annuity or disability insurance company or other health care provider to release and disclose my entire medical record without restriction.

The protected health information is to be disclosed under this authorization so that The Insurance Group may:

1) assist in the underwriting of my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance companies named below.

Accordia	Banner	Midland National	PRUCO Life Insurance Co
AIG Life	F&G	Minnesota Life	Royal Neighbors
Allianz	Genworth	NACOLAH	Transamerica
American General	John Hancock	Nationwide	Voya (formerly ING)
American National	Life of the Southwest	Principal Life	Other: _____
Assurity	Lincoln National	Principal National Life	
AXA	Met Life	Protective	

This authorization shall remain in force for 24 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 Insurance Group, 9330 LBJ Freeway, Suite 350, Dallas, TX 75243. I understand that a revocation is not effective to the extent that 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 or to contest the policy itself. I understand that any information that is disclosed pursuant to their authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical records, The Insurance Group may not be able to process my application. I acknowledge that I will receive a copy of this authorization upon my request.

_____ _____
Printed Name of Proposed Insured Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Personal Representative Date

_____
Description of Personal Representative's Authority/Relationship to Proposed Insured

_____Printed Name of Witness/Agent

_____ _____
Witness/Agent Date