**Please submit this form to: Capital Marketing Group**
3319 Heritage Trade Blvd Suite 101 Wake Forest NC 27587
Phone 919-488-3686 or 800-433-0481 Fax 919-488-7101 or email to Agentservices@capmar.com
**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (HIPAA COMPLIANT)**

Applicant:_____ **Applicant Social Sec. Number _____-_____-_____**

**Companies:**

*21st Services*
*Accordia Life/ Global Atlantic Co*
*AIG/ US Life Ins Co of NY*
*Allianz*
*American General Life Insurance Co*
*American National Ins Co*
*Ashar Group*
*AXA Equitable Co*
*Banner Life Insurance Co*
*Berkshire Life Insurance Co of America*
*Canada Life Insurance Co*
*Capital Marketing Group / CAPMAR*
*Columbus Life*
*Companion Life*
*Coventry*
*Credit Suisse*
*EMSI*
*F&G Life / Old Mutual*
*Financial Dynamics Group, Inc*
*First Penn Pacific*
*Foresters Life*
*GE Financial Assurance Co*
*General American Life*
*Genesett Capital Corp*
*Genworth Financial*
*Guaranty Trust Life*
*Guardian*
*Habersham Funding, LLC*
*Hartford Life Insurance Company*
*ING Life Group Companies*
*ISC Services*
*Illinois Mutual*
*Jackson National*
*John Hancock Life Insurance Co*
*Life Insurance Company of Virginia*
*Lincoln Financial Group*
*Manhattan National Life*
*Manufacturers Life Insurance Co*
*Manulife of New York*
*Mass Mutual Financial Group*
*Maple Life Settlements*
*Metropolitan Life Insurance Co*
*Midland Life*
*Minnesota Life Insurance Company*
*MONY Life Insurance Co*
*Mutual of Omaha*
*National Life of Vermont*
*National Life Insurance Company*
*Nationwide*
*North American Company of Life and Health*
*Northwestern Mutual*
*Pacific Life Insurance Co*
*Peachtree*
*Penn Mutual Life Insurance Co*
*Performa Corp*
*Phoenix Home Life Insurance Co*
*Portsmouth*
*Presidential Life*
*Principal Financial Group/ Principal Life/ Principal National*
*Protective Life Insurance Co*
*Prudential Insurance Co Pruco Life Insurance Co*
*Pruco Life Insurance Co of NY*
*Reliastar Life - ING*
*Reliastar of New York Security Life of Denver*
*Standard Life Insurance Co*
*State Life Insurance*
*Sun Life of America/ Sun Life of Canada*
*Symetra Life*
*The Lifeline*
*Transamerica Investment Life*
*Travelers*
*Trinity Life Settlements, LLC*
*United of Omaha*
*Union Central Life insurance Company*
*United States Life of New York*
*UNUM/Provident Life*
*US Financial*
*Valley Forge Life Insurance*
*VOYA*
*West Coast Life*
*William Penn Life Insurance Co of NY*
*Zurich/Kemper Life*

The terms that follow have the respective meanings when used in this authorization:

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency BUREAU: Medical Information Bureau, Inc. AUTHORIZATION: Authorization to Obtain and Disclose Information

I hereby authorize any: (1)physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy, or other medical or health care facility that has provided treatment, services, or payment to me or on my behalf; (2)Insurance Support Organization; (3)Insurance or reinsurance company; (4)financial services organization, or (5)current or former employer to furnish or disclose the types of information described below to agents, employees and representatives of the above-referenced insurance companies.

I understand that such information includes records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, and may also include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, and mental illness, and the use of drugs or tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to the information requested by this Authorization. I instruct any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or health care facility that has provided treatment, services or payment to me or on my behalf to release and disclose my entire medical record without restriction.

I understand that the information obtained may be used by the insurance companies listed above and their employees, agents and representatives to: (1) underwrite my application for coverage; (2) make eligibility, risk rating, policy issuance and enrollment determinations; (3) obtain reinsurance; (4) administer claims and determine or fulfill responsibility for coverage and provision of benefits; (5) administer coverage; and (6) conduct other legally permissible activities that relate to any coverage I have or have applied for with such company.

I understand that (a) this Authorization will be valid for 24 months from the date I sign it; (b) I may revoke this Authorizatoin at any time by providing written notice to the New Business Department at the address shown on the bottom of this form, subject to the rights of any person who acted in reliance on in it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

A copy of this Authorization is as valid as the original.

This Authorization Signed at _____ this _____ day of _____, 20 _____.

| | |
|---|---|
| Applicant: | **Complete if Minor Child is Proposed for Coverage** |
| Broker: | Name of minor child |
| Witness | Signature of Parent or Legal Guardian |