THE STAMM AGENCY

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that any life Insurance companies represented by The Stamm Agency in my behalf, their reinsurers, any insurance support organizations and the authorized representatives of these companies may need to collect Information on me in regard to proposed life insurance coverage. Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, Insurance or Reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources and employers to furnish to the insurance companies the types of Information specific In this Authorization upon presentation of this Authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to The Stamm Agency and Its affiliated corporations.

The types of Information will Include Information about drugs, alcoholism, my mental and physical health, other insurance coverage, participation In hazardous activities, character, general reputation, mode of living, finances, occupation and other personal characteristics.

The information will be used by the insurance companies and their reinsurers to determine insurability, claims, and/or by the Insurance agent to aid In updating and improving my insurance program.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance companies or as may be otherwise legally allowed.

Since The Stamm Agency and Its affiliated corporations are wholesale facilities and act primarily as a conduit to facilitate a relationship between the proposed Insured's agent and life insurance companies, the proposed Insured agrees that In the event of any litigation instituted by the proposed Insured and/or policy-owners, beneficiaries, or assignees of policies which are issued on the proposed insured's life that the proposed insured will pay reasonable attorneys fees incurred by The Stamm Agency or any of its affiliated corporations in defense of the aforesaid litigation or in any representation related to the aforesaid litigation. I also understand that if I make application to a life Insurance company as a result of a tentative offer made by The Stamm Agency and its affiliated corporations, neither The Stamm Agency and its affiliated corporations nor my agent has any right to effect any coverage and that the coverage will only be In effect when a policy is issued, the premium has been paid and all conditions precedent are satisfied. I recognize the significance of the foregoing and accept the same. I also recognize that The Stamm Agency and its affiliated corporations shall not be liable for any representations made by my agent unless these representations are confirmed In writing by The Stamm Agency and its affiliated corporations. This Authorization will be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization. A photographic copy of this Authorization shall be as valid as the original.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices.

THIS IS NOT AN APPLICATION FOR THE ISSUANCE OF LIFE INSURANCE

Signed at _____ **this** _____ **day of** _____, **20** _____

(City, State) **I acknowledge that I have read the foregoing terms and understand the same.**

_____ _____

Witness · Agent Signature **Proposed Insured Signature**

Accordia Life Ins. Co.
Allianz Life Ins. Co.
American General Life
American National
Americo Financial Life
Ameritas Life
Ameritas Life of NY
Assurity Life Ins. Co.
AXA/Equitable
Banner Life
Companion Life
Fidelity Security Life
First Ameritas Life
First Metlife Investors
First Symetra Nat'l Life
Gerber Life
John Hancock Life Ins. Co.
John Hancock Life Ins. Co. of NY
LifeSecure Ins. Co.
Lincoln National Life
Lincoln Life & Annuity Co. of NY
Lloyd's of London
MassMutual Life Ins. Co.
Metlife Investors USA Life Ins. Co.
Metropolitan Life Ins. Co.
Minnesota Life
Mutual of Omaha
National Western Life
Nationwide Life Ins. Co.
North American L&H
New York Life Ins. Co.
OneAmerica
Principal Life Ins. Co.
Principal National Life
Protective Life
Prudential Financial
Reliastar Life Ins. Co. (VOYA)
Reliastar Life Ins. Co. of NY (VOYA)
Security Life of Denver (VOYA)
State Life Ins. Co
Symetra Life
The Stamm Agency
Transamerica Financial
Transamerica Life
United of Omaha
Voya Financial
William Penn Life Ins. Co.

THE STAMM AGENCY HIPAA AUTHORIZATION IS ALSO REQUIRED

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____ , authorize _____
(Patient or Legal Representative) (Name of physician/ health care provider releasing records)

To disclose to:

The Stamm Agency / Express Imaging Services. Inc.

The Stamm Agency
2101 NW Corporate Blvd
Suite 320
Boca Raton, FL 33431
(800) 327-0176

Express Imaging Services, Inc.
PO Box 773
Torrance, CA 90501
(888) 846-8804

The following protected health care information:
Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.

Entire medical records for specific date(s) of service: From: _____ To: _____

Only the following specific information:

_____
_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below: _____ please initial

- Psychological/ Psychiatric Conditions
- Drug and/or Alcohol Abuse diagnosis and/or treatment
- HIV/AIDS diagnosis and/or testing
- Sexually transmitted disease(s) diagnosis and/or testing
- Genetic testing

List any restrictions _____

This protected health information is to be disclosed under this Authorization so that The Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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.

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has legal right to contest the policy or claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorized form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in 24 months and that a copy of this authorization is as valid as the original.

Signature of Patient or Legal Representative(s): _____
(Note: If patient is a minor child, both parents may be required by law to sign)

Date: _____ Printed Name(s): _____

Relationship to Patient: _____
(if signed by other than patient)