Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

This is not an application for insurance. No insurance will be issued as a result of the completion of this form.

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Name of proposed insured/patient *(please print)* Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, insurance company, medical practitioner, medical facility or medical related facility, insurance laboratory, Pharmacy Benefit Manager, the Medical Information Bureau, Inc., consumer reporting agency, applicable State Motor Vehicle Departments, or employer or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my 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 or my minor children to any of the following entities or their legal representative:

M Financial Holdings Incorporated, its subsidiaries or reinsurer(s); First American Insurance Underwriters (FAIU); the following insurance companies, their subsidiaries or reinsurer(s) – Allianz, Allstate, American General Life / AIG; American National, AVIVA Life Insurance Company, AVS LLC, AXA Equitable Life Insurance Company, Banner Life, Companion of NY, Coventry, Credit Suisse, Crump Insurance Services, Empire General, Gentry Partners, Genworth Life, Genworth Life Insurance Company of NY, Goldman Sachs Group, Guardian Life Insurance Company, Exceptional Risk Advisors, Hartford Life, Illinois Mutual, Independent Funding LLC, Indianapolis Life, Jackson National Life Insurance Company, John Hancock Life Insurance Company, Lifeline, Life Options, Life Settlement Solutions, Lincoln Benefit Life Company, The Lincoln National Life Insurance Company, Manulife Financial, Mass Mutual Life Insurance Company, MetLife Insurance Company, Midland National Life Insurance Company, Minnesota Life Insurance Company, Mutual of Omaha, National Life, Nationwide Financial, Nationwide Provident, New York Life, North American Life & Health, Ohio National Life Insurance Company, Old Line Life, Pacific Life Insurance Company, Penn Mutual, Phoenix Life, Principal Life Insurance Company, Principal National Life Insurance Company, Premier Brokerage, Protective Life, Protective Life & Annuity of NY, The Prudential Insurance Company, ReliaStar Life Insurance Company, ReliaStar of New York, Security Life of Denver Insurance Company, Standard Insurance Company, Sun Life, Symetra, TIAA-CREF Life Insurance Company, Transamerica Life Insurance Company/ TLIC, Trinity Financial, Union Central, United States Life Insurance of NY, UNUM Life Insurance Company of America, Voya, Welcome Funds, Inc., West Coast Life, William Penn Insurance Company of NY, Zurich America Life Insurance Company; and Heirmark, a Member Firm of M Financial Group.

I understand that the Insurance Companies have requested that I provide a blood, urine/and or oral fluid specimen(s) for testing by a licensed laboratory to assist in determining my insurability and that I will be provided information regarding the collection of such specimens prior to collection, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. I also understand that additional lab tests to be performed on my specimen(s) may include, but are not limited to, determinations of blood cholesterol and related lipids, screening for liver or kidney disorders, diabetes, hepatitis, immune disorders, Prostate Specific Antigen testing (a test for disorders of the prostate including prostate cancer), the presence of nicotine (cotinine), certain prescription medications, and drugs of abuse. Other tests may be performed on the specimen(s) as directed by the Insurance Company(ies).

By my signature below, I terminate any agreements I have made with My Providers to restrict my medical records and any associated HIPAA protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.
Protected health information is to be disclosed under this Authorization so that the Insurance Companies may determine whether they might consider offering me insurance coverage or benefits and for purposes of insurance underwriting. I understand that no insurance will be issued except on the basis of a signed, completed application of the respective Insurance Company.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My health care provider may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize my health care provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have questions about the disclosure of my health information, I can contact my health care provider.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Heirmark at 7005 S. Edgerton Rd., Ste. 101, Cleveland, OH 44141. I understand that a revocation is not effective if and to the extent that any of my Providers and/or the Insurance Companies have relied on this authorization. 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.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

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Signature of Proposed Insured/Patient or Personal Representative Date

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Description of Personal Representative's Authority or Relationship to Proposed Insured

Securities and Investment Advisory Services Offered Through M Holdings Securities, Inc. a Registered Broker/Dealer and Investment Adviser, Member FINRA/SIPC.
Heirmark LTD is independently owned and operated.