HIPAA AUTHORIZATION

Name: _____ Birthdate: _____ SS#: _____

PRINT NAME OF PATIENT

INFORMATION TO BE RELEASED FROM:

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other health care provider, insurance company, life settlement underwriter (life expectancy provider), life settlement provider, or other organization, institution or person, that has provided payment, treatment or services to me or has any records or knowledge of me or my health, to give such information to any of the life insurance companies or their reinsurers, life settlement underwriters, life settlement providers, life expectancy companies or other financial services intermediaries listed on this notice. I hereby authorize any company listed on this authorization to disclose any and all information related to my application to Valmark Securities, Inc., Executive Insurance Agency, Inc. and its agents/reprsentatives and their respective staff (collectively, "Valmark").

The purpose of this disclosure is to provide Valmark with the information necessary to provide me with ongoing advice and service. This protected health information is to be used or disclosed under this Authorization so that Valmark and the authorized parties listed below may: 1) underwrite my application for life and/or long term care insurance; 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; 5) evaluate and obtain life settlement offers; and 6) conduct other legally-permissible activities.

INFORMATION TO BE SENT TO:

To facilitate rapid submission of information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any of the companies listed below in this section:

Companies: Abacus Settlements, Accordia Life, Allianz, American General, American National, Americo Financial, APPS Paramedical Services, American Viatical Services, Apex Settlement Group, LLC, Athene, AXA, Banner Life, Berkshire Settlements, Blue Sky Reinsurance, BMI Financial, Brighthouse Financial, Clinical Reference Laboratory, CMG Surety, Corry Capital, Coventry First, Credit Suisse, Diamond Capital, DI Brokers East, EMSI, ExamOne, Exceptional Risk Advisors, Fairmarket LS Corp., Fasano Associates, First Financial, Genworth, Gen Re Life Corp, Global Atlantic Financial Group, Guardian, Habersham Funding, Hannover Re, Hartford, Human API, ING, IMS Paramed, Institutional Life Services, ISC Holdings LLC.dba (ISC Services) ITM Twentyfirst, Jefferson Pilot, JetStream APS, John Hancock, LabOne, Lapetus Life Event Solutions, Lexis Nexis, LifeMark Partners, LifeTrust LLC, The Lifeline Program, Life Capital Group, Life Equity, Life Plans, Life Policy Leads, Life Policy Traders, Lincoln Benefit, Lincoln Life, Lloyds of London, Lombard International Life Assurance Company, Longevity Services, Magna Life Settlements, Maple Life, Met Life Investors, Mass Mutual, Midland National, Milestone Providers LLC, Milliman IntelliScript, Minnesota Life, Montage Financial Group, Munich Re, Mutual of Omaha, Nationwide, Nation's Care Link, New York Life, Peachtree, North American Company, Ohio National, OneAmerica, Pacific Life, Penn Mutual, The Penn Insurance and Annuity Company of New York, Petersen International, Phoenix, Polaris Underwriting Technologies, Portsmouth, Portamedic/Hooper Holmes, Predictive Resources, Principal Life Insurance Company, Principal National Life Insurance Company, Protective, Proverian, Prudential, Q-Capital, Silver Point Capital, RGA, RSA Medical, RiskRighter, SBLI, Securian, The Settlement Group, The Standard, Sun Life, Swiss Re, Symetra, Transamerica, United of Omaha, U.S. Financial, Vespers Financial Group, Valmark Securities, Voya Financial, West Coast Life, Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York, 21st Services.

Mail to:

Jetstream APS	1663 Sawtelle Blvd, Suite 210, Los Angeles, CA 90025	(310) 826-3759
NAME OF RECORDS PROCUREMENT SERVICE	STREET ADDRESS	CITY | STATE ZIP PHONE NUMBER

This service is acting on behalf of Valmark, 130 Springside Dr., Suite 300, Akron, Ohio 44333 (800) 765–5201 and information may be released to Valmark.

INFORMATION TO BE RELEASED:

☐ The most recent five (5) years of pertinent information (chart notes, labs, x-rays and special tests)

☐ Specific information: _____

Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing or treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

HIPAA AUTHORIZATION

MY RIGHTS:

This authorization shall remain in force for 12 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 providing written notification to Valmark, 130 Springside Drive, Suite 300, Akron, Ohio, 44333. However, any action taken in reliance on this authorization prior to the notice of revocation shall be valid. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed except as authorized by me or as required by law.

I understand that refusing to sign this authorization will not prevent my ability to get treatment, payment, enrollment, or eligibility for benefits. This includes research-related treatment.

I further understand that if I refuse to sign this authorization to release my complete medical record, the financial services entity(ies) listed may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a copy of this authorization upon request.

Signature of Patient*: _____ Date: _____

**If guardian or authorized representative, print name below signature and provide documentation to prove authority to sign on behalf of patient.*

For Internal Use Only

_____ _____

NAME OF DESIGNATED FACILITY OR PROVIDER ADDRESS