AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

HIPAA COMPLIANT

Mailing Address:
901 Wilshire Dr., Ste. 140
Troy, MI 48084
Phone: (248) 356-7587
Fax: (248) 603-3595
www.pfnins.com

I understand that PLUS Financial Network, and its staff, the insurers PLUS Financial Network represents and their reinsurers, any insurance support organization and their authorized representatives may need to collect information about me in regard to obtaining insurance coverage.

Therefore, I authorize any physician, medical practitioner, medical examination company, hospital, clinic or other medical facility or medical-related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), Motor Vehicle Report (MVR), Prescription Drug Report (PDR), consumer reporting agency (CRA), or employer having information available as to the diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me to give the insurers listed below, their reinsurers and authorized representatives all such information. This information may include, but is not limited to, documents relating to my mental and physical health, office notes, laboratory studies, pathology reports, test results, mental health records, psychotherapy notes, drug/alcohol abuse, treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("information"). To facilitate rapid submission of such information, I authorize all said sources to give information and records to PLUS Financial Network, its staff and its authorized representatives.

I understand and agree that the information obtained by use of this Authorization will be used by PLUS Financial Network and/or insurers listed below and their authorized representatives to determine eligibility for insurance, and eligibility for benefits under existing policies. Any information obtained will not be released by PLUS Financial Network EXCEPT to one or more of the insurers listed below, their reinsurers, the MIB, my insurance agent or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize. I understand that the recipient of information disclosed pursuant to this Authorization may re-disclose the information and that, once disclosed, the information may no longer be protected by state or federal law.

I agree this Authorization shall be valid for two (2) years from the date shown below, unless I revoke it sooner, or in the event of a claim for benefits, for the duration of such claim. I understand that I have the right to revoke this Authorization in writing, mailed via certified mail, return receipt requested, to PLUS Financial Network at the mailing address provided above. I understand that a revocation is not effective to the extent that PLUS Financial Network or others have relied on the protected health information disclosed pursuant to this Authorization prior to its revocation.

I understand the execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand that my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the insurers listed below.

I acknowledge that I have read and understand the above and agree that this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were the original and can be relied upon by PLUS Financial Network and/or any third party designated herein.

PLUS Financial Network represents the following insurers: Accordia Life, Allstate, American General/AIG Companies, American Equity, American National, Ameritas, Assurity Life Insurance, Athene, AXA/Equitable, Banner Life, Chesapeake Life, Cincinnati Life, Fidelity Life, Fidelity Security Life, Genworth Life Insurance Company, Genworth Life & Annuity, Great American Life, Guarantee Trust Life, Guggenheim Life and Annuity, Hartford, Kemper, John Hancock Life, LifeSecure, Lincoln Benefit Life, Lincoln National Life, Mass Mutual, MetLife Investors, Metropolitan Life, Minnesota Life, Mutual of Omaha, National Guardian Life, National Life Group, National Western Life Insurance, Nationwide, North American Company for Life and Health, OneAmerica, Presidential, Principal, Principal National Life Insurance, Principal Life Insurance Company, Protective Life, Prudential Life/Pruco, SBLI, State Life, Sun Life of Canada, Symetra, Transamerica Life, Union Central Life, United Home Life, United of Omaha, Voya, Western National and Zurich.

Signed this_____ day of _____, 20_____

_____

Signature of Proposed Insured/Parent or Guardian Date of Birth

_____

Proposed Insured/Parent or Guardian *(Please Print)*

_____

Agent/Witness

PLUS FINANCIAL NETWORK
INNOVATIVE INSURANCE STRATEGIES FOR THE MODERN WORLD