Carriers

21st Century
Allianz
Allstate
American General Life
American National
APS Workflow
Aviva
AXA Equitable
Banner
Coventry
EMSI
Genworth Financial
Hartford
Indianapolis Life
ING
Integrity Life Solutions
John Hancock
Lincoln Benefit
Lincoln Financial
Mass Mutual
Met Life
Midland National
Mutual of Omaha
National Western
Nationwide
New York Life
North American
Northwestern Mutual
Pacific Life
Penn Mutual Life Insurance Co.
Phoenix Mutual
Principal Financial
Protective
The Prudential Insurance Company of America and Its Affiliated Companies
Savings Bank Life Insurance
Strategic Medical Consulting, Inc.
Sun Life
Superior Mobile Medics
Transamerica Occidental Life Ins. Co.
United of Omaha
United States Life
West Coast Life
Western Reserve Life
William Penn

Authorization for Release of Health Related Information to VIP Insurance and Its Companies

This authorization complies with HIPAA Privacy Rules

Name of Proposed Insured / Patient (Please Print)	/ / Date of Birth	- - Social Security Number

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, insurance company, insurance support organization, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record(s) including inspection report(s) and any other protected health information concerning me to Volente Insurance Partners, LLC ("the Company") and its agents, employees, representatives and companies. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes. This information will not be released to the insurance carriers or any other party without the Proposed Insured's written consent and individual company's consent.

By signing below, I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under the Authorization so that the Company may: 1) provide information to companies so the companies may underwrite my application for coverage by making eligibility, risk rating, policy issuance and provision of benefits; 2) administer coverage: and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 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 sending a written request for revocation to the Company at 1200 Cottonwood Creek Trl, Suite 800, Cedar Park, TX 78613, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule).

I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

X _____ _____

Signature of Proposed Insured / Patient or Personal Representative **Date**

_____

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

VIP HIPAA

Please provide the name, address and phone number of all physicians seen in the last five years:

1. Physician's Name: _____
   Address: _____
   Phone Number: _____
   Date Last Seen: _____
   Reason For Visit: _____
   _____

2. Physician's Name: _____
   Address: _____
   Phone Number: _____
   Date Last Seen: _____
   Reason For Visit: _____
   _____

3. Physician's Name: _____
   Address: _____
   Phone Number: _____
   Date Last Seen: _____
   Reason For Visit: _____
   _____

VIP Qualifying Questionnaire

Agent's Name: _____ Agent Phone Number: _____

Agent email: _____

Proposed Insured: _____

Face Amount : _____ DOB: _____

SS#: _____ Address: _____

Height: _____ Weight: _____ Tobacco usage: None Cigarettes Cigars Other _____

Please provide details as to usage (ie number of cigars/month; date last used) :

If quit using tobacco, please advise date last used and reason for quitting:

How was the need for this face amount and need for this life insurance determined?

Have you applied elsewhere and what were the results, offers?

If you are replacing coverage or have an insurance offer, what is causing you to continue to shop? (ie what is the need—premium you are trying beat, rating class, excluded coverage added back?)

Family history-	Current age	Age at death	Current health or cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____

Are you a US Citizen? If no, Visa Status and country of origin: _____

Please provide details to all foreign travel in the last 2 years , including any plans for future travel in the next year (feel free to add attachments):

VIP Qualifying Questionnaire , Cont.

Financial information-

Is the purpose of coverage personal or business? _____

If business coverage, what is the purpose, (ie key-man, creditor, buy-sell) ? _____

Occupation: _____ Income: _____

How was the face amount determined? _____

Have you filed for bankruptcy? If so, what type and has it been resolved?

Avocations-

Do you have any hazardous avocations, ie aviation, scuba, motor vehicle/motorcycle racing? _____

If so, please provide details including how often you engage in this activity:

Medical-

Please provide the name address and phone number of your personal physician: _____

Please advise the date and reason you last saw the physician: _____

Please advise all medications you are taking, the reason and for how long, including herbal and over the counter medications and supplements:

Have you been advised to have any tests or procedures that you have not yet had performed? If so please advise details.

Please advise any surgeries or health conditions (include cancer, heart or vascular disease, diabetes, sleep apnea, ulcerative colitis, irregular heartbeat, mental or nervous conditions, hepatitis, anemia or blood disorder, etc). We have questionnaires to help with 'yes' answers for details to conditions.