LWT
Leisure Werden & Terry

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency employer or other organization, institution or person having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition including prescription records and history of drugs prescribed, alcohol or drugs and/or treatment of me or my minor children and any other information of me or my minor children to give such information to: Accordia Life, AIG Life Brokerage, Corebridge Financial, American National Insurance Company, American Viatical Services, LLC, Athene, AXA Equitable, Banner Life Insurance Company, Braveport, Brighthouse Financial, Brighthouse Life Insurance Company, Coventry First, Genworth Financial Family of Companies, Gerber Life, ING USA Annuity and Life Insurance Company, Global Atlantic Financial Group, John Hancock Life Insurance Company, Legal and General Group LLC, Legal & General America, Leisure Werden & Terry Agency, Lincoln Financial Group, Mass Mutual Financial Group, Minnesota Life/Securian Financial Group, Mutual of Omaha Insurance Companies, Nationwide Financial, North American Company for Life and Health, New York Life, Pacific Life, PolicyOptions LLC, Principal Financial Group, Principal National Life Insurance Company, Principal Life Insurance Company, Protective Life Brokerage, Protective Life & Annuity, The Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, RSA Medical, Security Life of Denver Insurance Company, Symetra Life Insurance Company, 21st Services, The United States Life Insurance Company in the City of New York ,Transamerica Life Insurance Company, United of Omaha Life Insurance Company, Voya Financial, and William Penn Life Insurance Company of New York.

I UNDERSTAND the information obtained by use of the Authorization will be used by said companies to determine eligibility for insurance, eligibility for benefits under an existing policy and for other business purposes in connection with the insurance relationship. Any information obtained will not be released by said companies to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, other business purposes, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of the Authorization. I agree that 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. I agree this Authorization shall be valid for two and one half years from the date shown below.

I UNDERSTAND that I may revoke this authorization by sending a written request to revoke to the representative handling my application and that the revocation will be effective when it is received. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I UNDERSTAND that if I refuse to sign this authorization, that any of the named parties above may not be able to provide full and complete information about insurance coverage and its costs that may be available to me. I understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage.

☐ **I ELECT TO BE INTERVIEWED** if an investigative consumer report is prepared in connection with this application.

SIGNED THIS _____ **DAY OF** _____ **20** _____

NAME OF PRIMARY PROPOSED INSURED (PLEASE PRINT)

SIGNATURE OF PRIMARY PROPOSED INSURED

DATE OF BIRTH

SSN OF PROPOSED INSURED

NAME OF SECONDARY PROPOSED INSURED (PLEASE PRINT)

SIGNATURE OF SECONDARY PROPOSED INSURED

DATE OF BIRTH

SSN OF PROPOSED INSURED

rev 2/26/2024