Ryboeck, Inc. Client Authorization

This Authorization is HIPAA Compliant

Proposed Insured: _____

Date of Birth: _____ Social Security # _____

Purpose

The purpose of this HIPAA Authorization (the "Authorization") is to permit Ryboeck, Inc., and its affiliates to obtain nonpublic personal information about me, the insured named above, for the purposes of (1) to determine my eligibility for and obtaining Insurance products and services from one or more of the Insurers or institutions;(2) to monitor, track, or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore; and (3) to develop and use indices that do not personally identify individuals related to actual and anticipated longevity, mortality, life expectancies, and/or similar measures.

Information to be Released:

The term "Information" as used in this Authorization refers to the information to be released pursuant to this Authorization including but not limited to any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or condition ("information"), to the extent permitted by law. Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits. The term information does not include psychotherapy notes. I understand that this Information may include results from blood, saliva, urine, and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases, HIV infection, including medical test results.

Authorization:

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution (an Authorized HCP) that has Information about me to disclose any and all information to Ryboeck, Inc. and its agents and representatives. I also authorize my Agent, named below, to receive Information to assist in the purpose of this Authorization to the extent permitted by law.

I understand that Information disclosed to Ryboeck, Inc. may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to Ryboeck, Inc., it may no longer be subject to those laws and regulations. I understand that no Authorized HCP or covered entity may condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

A photocopy of this Authorization shall be as valid as the original. I will receive a copy of this Authorization.

Right to Revoke Authorization:

This Authorization shall be effective for two (2) years after the date signed below. I acknowledge and understand that I may revoke this Authorization any time with respect to any Authorized HCP my notifying such Authorized HCP in writing of my revocation of this Authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP, provided that, any revocation of this Authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this Authorization prior receiving written notice of my revocation.

_____ _____

Proposed Insured's Signature (or that of Authorized Representative) Date

_____

Print Name of Proposed Insured

_____

If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

_____

Print Name of Agent

_____

AUTHORIZATION OF INSURED FOR USE AND DISCLOSURE OF NON-PUBLIC INFORMATION

I,_____(the "insured"). Hereby authorize Ryboeck, Inc., and any of its affiliates, agents, employees, or representatives, or their respective successors and assigns, to use, and to deliver, disclose, give, provide and release, as may be necessary to effect the placement of a life insurance policy insuring the Insured's life (a "Life Insurance Policy"), any and all Non-Public Information (as defined below) to Ryboeck, Inc. and any of its affiliates, (of which a list is provided below) , and any of their respective agents, employees and representatives (each, an "Authorized Recipient") ad may be necessary to effect the placement of a Life Insurance Policy.

"Non-Public Information" means information, including, without limitation, non-public personal, financial, health and medical information about the Insured and the Insured's identity as an insured under a Life Insurance Policy that is obtained, whether from the Insured, any of the Insured's agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

The Insured hereby further authorized each Authorized Recipient to deliver, disclose, give, provide and release any and all Non-Public Information in connection with the placement of a Life Insurance Policy to any entity or person for the purposed of health or medical information review or underwriting.

The Insured agrees and consents that this Authorization of Insured For Use and Disclosure of Non-Public Information ("the authorization") shall be effective from the date hereof until the earlier of (a) the date that is two(2) years after the date hereof, or (b) such earlier date, if any, as may be required by applicable law or regulation. The insured agrees that any photocopy, facsimile or other reproduction of this Authorization shall be as valid as the original hereof and may be relied upon by any insurance company and any of his/her agents, designees, successors, or assigns.

The Insured certifies that he or she is executing and delivering this Authorization freely and unilaterally as of the date written below. The Insured further acknowledges and agrees that this Authorization is written in plain language and acknowledges that he or she has received and retained a copy of this signed Authorization for future reference.

Proposed Insured Initials: _____Date:_____

Print Name: _____ Soc. Sec.# _____

Allianz Life Insurance Company of New York
Allianz Life Ins. Co of North America
Allstate Life Insurance Company of N.Y.
American General Life/AIG
American Investors Life Ins. Co.
American National Ins Co.
Assurity Life
Aviva Life and Annuity Co.
AXA-Equitable
Banner Life
Companion Life of NY
Fidelity Security
First Met Life Investors Ins. Co
Genworth Life and Annuity Ins. Co
Genworth Life Ins. Co.
Genworth Life Ins Co of NY
Illinois Mutual
ING Reliastar Life Ins. Co.
ING Security Life of Denver
John Hancock (USA)
John Hancock Life Ins Co of NY
Liberty Life Assurance
Liberty Life Ins. Co.
Lincoln Benefit Life
Lincoln Financial
Lincoln Life and Annuity of NY
Lloyds of London
Mass Mutual
MetLife Investors
Metropolitan Life Ins Co.
Midland Life
Minnesota Mutual
Nationwide
Nationwide Provident
North American Life & Health
Pacific Life
Penn Mutual
Principal National
Protective Life
Protective Life and Annuity of NY
Prudential Financial
SBLI of Massachusetts
Security Mutual Life
Sun Life Financial
Sun Life Financial/Annuity
Sun Life Ins. & Annuity of NY
Transamerica Financial Life Ins. Co.
Transamerica Life Ins. Co.
Union Central
United of Omaha Life Ins. Co.
United States Life Ins. Of NY
West Coast Life
William Penn Ins Co of NY

Other:_____