

## 1. Personal Information

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Gender: (Male, Female) \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_ No. of Years: \_\_\_\_\_

Resident Status: (Citizen, Resident, Visa) \_\_\_\_\_ US tax resident? ☐ Yes | ☐ No

Driver's License No.: \_\_\_\_\_ Place of Issue: \_\_\_\_\_

Issued: (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Expires: (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Marital Status: (Married, Common-law, Divorced, Single, Other) \_\_\_\_\_

Spouse Name: \_\_\_\_\_ Date of Birth: (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ No. of Years: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Height: (ft/in) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_ Change of  $\pm 10$  lbs in last 12 months? ☐ Yes | ☐ No

Details: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

Details of last visit: \_\_\_\_\_

Medications: \_\_\_\_\_

Do you have, or have you been treated for, any of the following conditions: High blood pressure, High cholesterol, Cancer, tumours, leukemia, polyps or skin lesions, Diabetes, coronary or vascular issues, Depression or Anxiety, gastrointestinal issues such as Chrons or Colitis? ☐ Yes | ☐ No

Other Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Clinic Location: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has any parent or any sibling ever been diagnosed with heart disease, stroke, cancer, Huntington's chorea, kidney disease, Parkinson's, multiple sclerosis, Alzheimer's, ALS or Lou Gehrig's or other motor neuron disease, diabetes, hepatitis, kidney disorders or retinitis pigmentosa? ☐ Yes | ☐ No

Relation: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Age of Onset: \_\_\_\_\_ Current Age: \_\_\_\_\_ / Age at Death: \_\_\_\_\_ Cause: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Relation: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Age of Onset: \_\_\_\_\_ Current Age: \_\_\_\_\_ / Age at Death: \_\_\_\_\_ Cause: \_\_\_\_\_

Details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Notes:

[illegible]

### Authorization for Release of Health-Related Information

#### This Authorization complies with the HIPAA Privacy Rules

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize (Armstrong Financial Services, Armstrong Financial USA, IDC-WIN, ASG Life) (the "Representative"), and its affiliated agencies to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. 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.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA-protected health information do not apply for purposes of this authorization, and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing the privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement or the evaluation or underwriting for the possible procurement of life, health, long-term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies at the bottom of this page and their re-insurers, the Representative, its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken based on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that another law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also 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 understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services or my eligibility for health care benefits; provided, however, that if a health care service (e.g., a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Armstrong Financial  
Accordia Life  
ASG Life  
American General  
ANICO / Banner Life  
ExamOne / Dynacare  
William Penn  
Zurich American Life

Guardian Hooper  
John Hancock  
LIBRA Insurance  
Lincoln Life & Annuity  
Lincoln Financial Group  
MassMutual  
Metropolitan Life  
Mutual of Omaha

Nationwide  
New York Life  
Pacific Life  
Pan American Life  
Principal Life Insurance  
Principal National Life  
Protective Life  
Prudential Financial

Sagcor / SBLI  
SSQ / Beneva  
Security Mutual  
Symetra  
Transamerica Life  
Transamerica Financial  
Equitable Life  
Desjardins

Canada life  
BMO Insurance  
Manulife  
Sun Life  
Industrial Alliance  
Empire Life  
RBC Life

Agent/Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

