* * * Communication Result Report (Sep. 10. 2020 3:09PM) * * *

1)
2)

Date/Time: Sep. 10. 2020 3:04PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
2399	Memory TX	18775161476	P. 20	OK	

Reason for error
E. 1) Hang up or line fail
E. 2) Busy
E. 3) No answer
E. 4) No facsimile connection
E. 5) Exceeded max. E-mail size
E. 6) Destination does not support IP-Fax

paraMeds.com a PDC company 09/09/20

Attending Physician Statement Request

Case: 24392054

Medical Information REQUESTED FROM:

Longevity Medical Clinic
19221 36th Ave W Ste 210
Lynnwood, WA 98036

Attention: Longevity Medical Clinic
Fax: 14256701002

RELEASE Medical Information TO:

Country Life Insurance
Life Insurance
C/O PDC Retrievals
P.O. Box 150356
Kew Gardens,NY 11415

Fax: 1(877) 516-1476
Phone: 1(212)223-3228 ext.24392054

RELEASE Medical Information ON: *Please upload records using https://upload.parameds.com*

Sellentin, Jeffrey
DOB: 10/31/63 SSN: XXX-XX-7521
Address: UNITED STATES OF AMERICA, 785 16th Pl, Mukilteo, WA, 98275-2283 Phone: 001(206) 715-2452

TYPE of Medical Information to RELEASE:

Please provide only what is requested in the SPECIAL REQUEST section below.
Please do not send partial records as we will have to reorder the missing information.

SPECIAL REQUEST:

>>>> Please provide information for the last 4 years. <<<<

If the fee for records exceeds $230.00, or this release is not valid please call us at 1(212)223-3228 ext.24392054.

According to 'RCW 70.02.010 (37)' your charges should not exceed the following: 'Record Search Fee - $26.00. Per Page Fee - $1.17 per page 1-30 $.88 per page 31+.'

Electronic Signatures comply with Federal Electronic Signature statue, Title 15, U.S.C., Chap 96, Sec. 7001, et seq., and is fully legal and valid as an original. The department of Human Services has also expressly permitted the use of electronically signed authorizations.

NOTE:

Records needed urgently! Please fax or return records with UPS today, thank you very much!

For faster delivery UPLOAD these records to our secure HIPAA compliant website at www.parameds.com/upload

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PLEASE SEND THIS FORM BACK WITH THE REQUESTED MEDICAL RECORDS!

PDC-001-024392054-1001-0010-N

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09/09/20

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PDC-001-024392054-1001-0010-N

LONGEVITY MEDICAL CLINIC CUSTO
9757 NE Juanita Dr
KIRKLAND, WA 98034
4255769272

Date: 9/10/2020 | Time: 2:50:46 PM [PDT]

Trans Type:	Sale
Transaction #:	366101716
Name:	Paramedis Inc
Account:	**********0746
Exp Date:	****
Card Type:	MASTERCARD
Entry:	Manual
AuthCode:	933778
Result:	Approved
Message:	APPROVAL
Batch Number:	0
Total Amt:	**$52.09**

I Agree to Pay Above Total Amount According to Card Issuer Agreement (Merchant Agreement if Credit Voucher)

Signature X_____

Jeffrey Sellentin

Washington
Authorization for Release of Health-Related Information

(continued from previous page)

I understand laboratory testing may be required, and I voluntarily consent to the testing of my blood, urine, and/or oral fluid specimen(s) for HIV and illegal drug use.

I understand this authorization may be revoked in writing at any time by contacting the Home Office of COUNTRY Life Insurance Company or COUNTRY Investors Life Assurance Company. Revocation of this authorization does not extend to actions COUNTRY has already taken in reliance upon the authorization or the right of COUNTRY to use information to contest a claim under the policy or the policy itself.

Issuance of this policy is conditioned upon COUNTRY Life Insurance Company and COUNTRY Investors Life Assurance Company, and affiliates which are members of COUNTRY Financial receiving a fully and effectuated authorization. I understand COUNTRY cannot commence its underwriting process and issue a policy unless the authorization is signed. I understand COUNTRY will strive to keep my private information confidential. However, if at any time I disclose private information, it may be redisclosed in accordance with applicable law and may no longer be protected.

I authorize COUNTRY Life Insurance Company/COUNTRY Investors Life Assurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

I acknowledge that I have received a copy of this authorization.

Jeffrey Sellentin 08/20/2020

Signature of Proposed Insured and Date Signed
(If not a minor)

Signature of Spouse and Date Signed
(If coverage is applied for)
Scott Reitz 08/20/2020

Signature of Parent or Legal Guardian and Date Signed
(If Proposed Insured is a minor)

Signature of Insurance Producer/Witness

	First Name	Last Name	Date of Birth
Proposed Insured	Jeffrey	Sellentin	10/31/1963

Complete the following if applying for coverage:

	First Name	Last Name	Date of Birth
Spouse			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

Jeffrey Sellentin

Washington Authorization for Release of Health-Related Information

COUNTRY Life Insurance Company®
COUNTRY Investors Life Assurance Company®
1701 N. Towanda Avenue, PO Box 2000
Bloomington, IL 61702-2000
T 866-COUNTRY (866-268-6879)

	First Name	Last Name	Date of Birth
Proposed Insured	Jeffrey	Sellentin	10/31/1963

Complete the following if applying for coverage:

	First Name	Last Name	Date of Birth
Spouse			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

I authorize any physician, practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, other medically related facilities ("My Providers"), MIB, Inc., my employer, consumer reporting agencies, and insurance companies and their reinsurers who may possess health and financial information about me or any of my children named in the application to release such information concerning me, my children, or another for whom I am legally authorized to sign to COUNTRY Life Insurance Company® and COUNTRY Investors Life Assurance Company®, and affiliated companies that are members of COUNTRY Financial® (collectively, "COUNTRY"), and its reinsurers, insurance support organizations and their authorized representatives, affiliates, and nonaffiliated third parties as allowed by law. I authorize the release of my entire medical record and any other information that may be considered protected health information and financial or any other personal information. This includes information about health history, diagnosis, treatment, pharmaceutical records, or prognosis with respect to any physical or mental condition including drugs, alcoholism, mental illness, or HIV testing, occupation, income, tax and financial history, foreign travel, avocation, driving record, other personal characteristics and other insurance. **Per Washington Law, RCW 70.24.105, if I have been tested for any sexually transmitted disease, you are specifically authorized to release to the above named companies all information or medical records relating to diagnosis, testing or treatment of such disease.** The information authorized may include records involving psychiatric care, drug abuse, and/or alcoholism. I understand that this authorization is needed to gather such information that will be used by underwriters, medical professionals and other COUNTRY officers, employees and representatives to evaluate claims, life insurance and/or benefits applied for and other reasons necessary to facilitate my insurance transaction. The information may be shared by COUNTRY with its affiliates, contractors, reinsurers, authorized representatives, other insurance companies and unaffiliated third parties as allowed by law and as necessary to facilitate my transaction.

To facilitate rapid submission of such information, I authorize all said sources, except MIB, Inc. to give such records to any agency employed by COUNTRY to collect and transmit such information. I further authorize MIB, Inc. to transmit any relevant information to any agency employed by COUNTRY.

I understand that this authorization is valid for (6) months from the date it is signed and a photocopy and/or fax is also valid, except disclosure of HIV-related information in which case it is valid for 180 days.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, COUNTRY may not be able to obtain medical information necessary to consider my application.

* * * Communication Result Report (Sep. 10. 2020 12:17PM) * * *

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2)

Date/Time: Sep. 10. 2020 12:16PM

File No.	Mode	Destination	Pg(s)	Result	Page Not Sent
2394	Memory TX	18775161476	P. 2	OK	

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paraMeds.com
A PDC company

09/09/20

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PDC-DD1-024392054-1001-0010-N