

AUTHORIZATION TO OBTAIN & DISCLOSE INFORMATION

Aetna Life Insurance Co.	Coventry First	John Hancock Life of NY		Southwestern Life Ins. Co.
Allianz Life	Continental Assurance	Kansas City Life	Ohio National Life Assurance	State Life
Allianz Life of NY	Empire General	Kemper Investors	Ohio National Life Ins.	Sun Life & Annuity
American General	Equitable Life of IA - ING	Lafayette Life	Pacific Life	SunAmerica Life Ins.
American Life Ins. Co.	EquiTrust Life Ins.	Liberty Life	Paul Revere Life	Transamerica Financial Life
American National	Fidelity & Guaranty	Life Investors	Penn Mutual	Transamerica Life
American Skandia	Fidelity & Guaranty of NY	Lincoln Benefit Life	People's Benefit	Transamerica Life & Annuity
AmerUs Life Ins.	First Colony Life	Lincoln Life & Annuity Co. of NY	Phoenix Life	Transamerica Occidental
Assurity Life Ins. Co.	First Penn-Pacific	Lincoln National Life Ins. Co.	Physicians Life Ins. Co.	Travelers Ins. Co.
Aviva Life	General American	MassMutual	Physicians Mutual	Travelers Life & Annuity
Aviva Life Ins. Of NY	Gerber Life	MetLife Invest USA	Presidential Life Ins.	Union Central
AXA Equitable Life Ins. Co.	Great American	MetLife Investors	Principal Life	United of Omaha
Bankers Life of NY	Guarantee Trust Life	Metropolitan Life Ins. Co.	Protective Life	United State Life
Banner Life	Guardian Life	Midland National	Provident Life & Acc.	UNUM Life of America
Boston Mutual	Hartford Life	MML Bay State Life	PRUCO Life Ins. Co.	US Financial
Chase Ins. Life & Annuity	Illinois Mutual	MONY Life Ins. Co.	PRUCO Life of NJ	USG Annuity & Life
Chase Ins. Life of America	ING Life Ins. & Annuity	MONY Life of America	Prudential Financial	Valley Forge Life Ins.
Chase Ins. Life of NY	Integrity Life	National Life Group	Reassure America Life	Viatiscus
Cincinnati Life Ins. Co.	Jefferson Pilot Financial Ins. Co.	Nationwide Life	Reliastar Life - ING	West Coast Life
Clarica Life Ins. - US	Jefferson-Pilot Life Ins. Co.	New England Life Ins. Co.	Reliastar Life of NY - ING	Western Reserve
CM Life Ins. Co.	Jefferson-Pilot LifeAmerica	New York Life	Security Benefit	William Penn of NY
Columbian Mutual	John Alden Life	New York Life & Annuity	Security Life of Denver - ING	
Companion Life of NY	John Hancock Life	North American Co. for L&H	Security Mutual of NY	
Conseco Ins. Co.	John Hancock Life (USA)	North American Co. for L&H NY	Southland Life-ING	

The terms that follow have respective meaning when used in this Authorization.

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU: Medical Information Bureau, Inc.
AUTHORIZATIONS: Authorization to Obtain and Disclose Information

I understand that any Company named above, its re-insurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) re-insurer; (6) insurance support organizations; (7) financial source; and (8) employer, to furnish the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original. To facilitate rapid submission of such information, I authorize all said sources, except Medical Information Bureau, Inc. to give such records or knowledge to The New Jersey Regional Office.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; and (9) other personal traits.

The Companies named above and their re-insurers will use the information in order to determine whether I am insurable. The insurance agent may also use this information to help update and improve my insurance program.

Those parties named in the first paragraph of this Authorization may disclose the information that they have collected. They may disclose this information to (1) other insurers to which I have applied or may apply; (2) re-insurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be allowed by law.

A photographic copy of this Authorization and acknowledgment shall be as valid as the original. This Authorization will be valid for 30 Months after the date it is signed (two years in R.I.). I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). I understand that I or my authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

Signed at _____ this _____ day of _____,

Signature of Proposed Insured (Parent of proposed insured is a minor)

**Authorization for Release of Health-Related Information to
AMERICA'S PARTNERS, LLC/SEQUOIA PREMIER PARTNERS/SEQUOIA FINANCIAL
NETWORK/ADVANTAGE INSURANCE NETWORK/CPS INSURANCE/THE PRODUCERS
NETWORK**

This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
_____	_____
_____	_____
_____	_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, 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 protected health information concerning me to The Regional Office and its authorized representatives. 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 to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that The Regional Office: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have applied for with the Company.

This Authorization shall remain in force for 30 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 at 1030 W. Higgins Rd. Suite 212, Park Ridge, IL 60068, Attention: Underwriting. I understand that a revocation is not effective to the extent that 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 an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make benefit payments.

Signature of Proposed Insured, Patient, or Personal Representative	Date
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Signature of Proposed Insured, Patient, or Personal Representative	Date
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Signature of Proposed Insured, Patient, or Personal Representative	Date
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Description of Personal Representative's Authority or Relationship to Patient

America's Partners
847-489-4475
fax 847-518-0062
david@americaspartner.com