



# Authorization for the release of Personal Health Information

\_\_\_\_\_  
Name of Proposed Insured (please print)

\_\_\_\_\_  
Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to any one (or all) of The Specific Solutions Group of companies ("The Company"), its agents, employees, insurance support organizations, insurers, reinsurers, and their representatives. This includes information concerning 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 (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by The Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that The Company may; 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance offers; and 3) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for through The Company.

The following groups of persons employed or working for The Company may use my personal health information which is described above: employees of the underwriting, administration, and any other personnel of The Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with The Company.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure.

This authorization shall remain in force for 24 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 at any time. The request for revocation must be in writing and sent to: The Specific Solutions Group, 475 International Dr., Williamsville, NY 14221. I understand that a revocation is not effective if The Company has relied on the protected health information disclosed to it. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

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 for coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon receipt of your signed authorization, a copy will be provided to you. Any alteration of this form will not be accepted.

X \_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative

\_\_\_\_\_  
Date

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (parent, legal guardian, power of attorney, etc.) on the line above.

# COMPANY AUTHORIZATION FORM

Form# CAF-926  
Revised: March 2022

AMERICAN GENERAL LIFE INSURANCE CO  
AMERICAN NATIONAL LIFE INSURANCE CO  
AMERICAN NATIONAL LIFE INSURANCE CO OF NY  
AMERITAS LIFE INSURANCE CORP  
AMERITAS LIFE INSURANCE CORP OF NY  
ASSURITY LIFE INSURANCE CO  
ATHENE LIFE INSURANCE CO  
ATHENE LIFE INSURANCE CO OF NY  
BANNER LIFE INSURANCE CO  
COLUMBIAN MUTUAL LIFE INSURANCE CO  
COMPANION LIFE INSURANCE CO  
EQUITABLE LIFE INSURANCE CO  
FIRST SYMETRA LIFE INSURANCE CO OF NY  
FIRST UNUM LIFE INSURANCE CO  
GENWORTH LIFE INSURANCE CO  
GENWORTH LIFE INSURANCE CO OF NY  
JOHN HANCOCK LIFE INSURANCE CO  
JOHN HANCOCK LIFE INSURANCE CO OF NY  
LIFE INSURANCE CO OF THE SOUTHWEST  
LINCOLN LIFE AND ANNUITY CO OF NY  
LINCOLN NATIONAL LIFE INSURANCE CO  
MASSACHUSETTS MUTUAL LIFE INSURANCE CO  
MINNESOTA LIFE INSURANCE CO  
MUTUAL OF OMAHA  
NATIONAL LIFE INSURANCE CO  
NATIONWIDE LIFE INSURANCE CO

NORTH AMERICAN CO FOR LIFE AND HEALTH  
ONEAMERICA  
PACIFIC LIFE  
PENN INSURANCE AND ANNUITY CO OF NY  
PENN MUTUAL LIFE INSURANCE CO  
PRINCIPAL LIFE INSURANCE CO  
PRINCIPAL NATIONAL LIFE INSURANCE CO  
PROTECTIVE LIFE AND ANNUITY INSURANCE CO  
PROTECTIVE LIFE INSURANCE CO  
PRUCO LIFE INSURANCE CO  
PRUCO LIFE INSURANCE CO OF NJ  
PRUDENTIAL INSURANCE CO OF AMERICA  
SAVINGS BANK LIFE INSURANCE CO OF MA  
SECURIAN LIFE INSURANCE CO  
SECURITY MUTUAL LIFE INSURANCE CO OF NY  
SYMETRA LIFE INSURANCE CO  
THE STANDARD LIFE INSURANCE CO  
THE STANDARD LIFE INSURANCE CO OF NY  
TRANSAMERICA FINANCIAL LIFE INSURANCE CO  
TRANSAMERICA LIFE INSURANCE CO  
UNITED OF OMAHA LIFE INSURANCE CO  
UNITED STATES LIFE INSURANCE CO  
VANTIS LIFE  
WESTERN SOUTHERN  
WILLIAM PENN LIFE INSURANCE CO OF NY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give any such information to The Specific Solutions Group or any one of the life insurance companies listed and its reinsuring companies.

A photographic copy of this authorization and acknowledgment shall be as valid as the original.

\_\_\_\_\_ X \_\_\_\_\_  
Date Signature of Proposed Insured (or Parent, if Proposed Insured is a Minor)



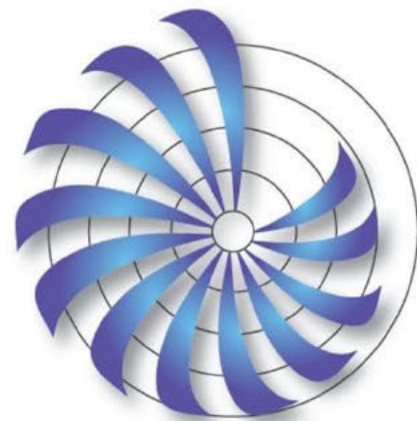
## The Specific Solutions Group

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agency@specificsolutions.com

# App-Solution

## How to be prepared for your Upcoming insurance interview



App-Solution Date: \_\_\_\_\_

App-Solution Time: \_\_\_\_\_

### Fast FAQ's

- How long will this interview take?
  - Approx. 20-30 minutes
- Will I have to have another interview?
  - It is possible you will need a short medical exam done
- What if I do not know an answer?
  - Answer the questions to the best of your knowledge
- What if I have product questions?
  - We will ask that your Insurance Agent answers those questions
- Do I automatically have insurance coverage?
  - No, not until your agent tells you the policy is in effect



### Documents you will need for the interview

1. Driver's License number and Social Security Number
2. Names, addresses and phone numbers of doctors, hospitals/clinics you've visited in the past 10 years
3. Reason for and dates of medical treatment
4. Names of any prescription medicines you are taking
5. Other life insurance policies including company names, coverage amounts and policy numbers
6. Financial information including income, assets, liabilities and net worth

### Next Steps

Once the phone interview is complete, the application will be emailed to your agent to finalize the application. You and your agent will review and sign the application. Once that is done, the completed application will be sent to Specific Solutions. At that time we will begin to process the application. Once a policy is issued, we will send that to your agent to collect any money and/or signatures required.



**SPECIFIC SOLUTIONS, INC.**

The Life, Annuity, Long Term Care, & Disability Income Problem Solvers