Authorization to Obtain Information/ Waiver and Acknowledgement

Authorization:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (my providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Lovett Financial Inc. and its agents, employees, representatives and associated parties. 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 signing below, I terminate any agreements I have made with my providers to restrict my protected health information and I instruct my providers to release and disclose my entire medical record without restriction.

I understand my protected health information is to be disclosed under this authorization so that Lovett Financial Inc. may: 1) underwrite my application for coverage by making eligibility, risk, rating, policy issuance and enrollment determinations; 2) obtain insurance: and 3) conduct other legally permissible activities that pertain to any coverage I have or have applied for with the insurance companies named below:

____
Proposed insured name (please print)

____ ____________________
Proposed insured's Signature / Guardian or Custodian / Authorized Representative Date

AIG / American General
AIG Annuity Access
Allianz
Allianz Life of NY
Allstate Life of NY
American National
American Investors Life
Assurity
Accordia
AXA Equitable
Banner Life
Columbus Life Insurance Company
Companion Life of NY
Equitable Life and Casualty
Equitrust
Fidelity Life
Fidelity Security
Genworth Life
Genworth Life & Annuity
Genworth Life of New York
Guaranteed Trust Life
Illinois Mutual
Integrity Life
John Hancock Life
John Hancock LTC
John Hancock of NY
John Hancock of USA
Lafayette Life
Life of the Southwest
Lincoln Life of NY
Lincoln National
Liberty Life/RBC
Lloyd's of London
Mass Mutual
MedAmerica
MetLife Insurance
MetLife DI
MetLife LTC
Midland National
Minnesota Life
Mutual of Omaha
National Guardian
National Integrity Life
National Life
Nationwide
New York Life
North American
Ohio National
Pacific Life
Penn Mutual
Petersen International
Phoenix Life
Presidential Life
Principal
Principal National
Protective Life
Prudential Life
Reliance Standard
Sagicor Life
SBLI
Security Mutual of NY
Standard Insurance Company
State Life/One America
Symetra Life
The Guardian Life Insurance Co
Transamerica
UNIFI Companies
United of Omaha
US Life of New York
Voya Financial
Western Reserve Life
William Penn of NY
Zurich

Other Company:____

Lovett Financial will employ its best efforts to disclose information only to insurance companies deemed necessary

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 in writing, at any time, by sending a written request to Lovett Financial Inc. I understand that a revocation is not effective if any of my providers has relied on this authorization or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality.

Revised 12/1/2015.

WAIVER AND ACKNOWLEDGEMENT:

This waiver and acknowledgement has been signed on the date set forth below by the undersigned in favor of Lovett Financial Inc., its successors, assigns, shareholders, directors and employees (collectively "Lovett Financial").

Applicant acknowledges, understands and agrees as follows:

- That applicant has filed an application with Lovett Financial intending to secure life insurance from one or more insurance writers.
- That, in the course of applying for life insurance coverage, Lovett Financial has asked for and received information concerning applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- That Lovett Financial will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- That Lovett Financial maintains an electronic data interchange through which certain Authorized underwriters and/or other insurance industry representatives may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those underwriters.
- That Lovett Financial will use the interchange to store some or all of the confidential and personal information applicant has provided, and, therefore, that underwriters will be able to gain access to that information through the interchange.
- That the underwriters will gain access to the interchange via the internet or other, similar computer-based telecommunications systems.
- That, even though Lovett Financial has in place security measures Lovett Financial believes appropriate to protect the information from unauthorized access and use, and even though Lovett Financial can make no guarantee as to the ability to protect information it contains from unauthorized access by hackers or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the information.
- That Lovett Financial cannot control the use, dissemination, publishing or interpretation of the information contained in the information once gathered by an underwriter.
- That applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to applicant in Lovett Financial Inc. possession and/or stored.
- That applicant will indemnify Lovett Financial for all costs and expenses incurred by Lovett Financial or any of its employees, directors or agents in enforcing this waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I **ACKNOWLEDGE** that I have received a copy of this document.
I **AGREE** this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: _______/________/_______

City:____________________________ State:_________ Insured's DOB __________________

Insured ____ Insured's SSN _________________________
(Printed Name of Proposed Insured/Parent or Guardian)

X____ X____
(Signature of Proposed Insured/Parent or Guardian) (Signature of Witness)