19000 MacArthur Blvd, Suite 450
Irvine, CA 92612
P: 714-820-4489 • F: 714-627-4646
www.AdvisorHQ.com

AUTHORIZATION FOR RELEASE OF INFORMATION OF INSURED

By executing this Authorization for Release of Information of Insured (this "Authorization Form"), the undersigned authorizing person, who is and/or seeks to be insured (the "Insured") under one or more life insurance policies, or who is duly authorized to act on behalf of the Insured if not the Insured, acknowledges the necessity for personal and protected health, medical, and other information, documentation, and records regarding the Insured to be released to Insurance Marketing Services, Inc., d/b/a Advisor HQ and d/b/a Advisor HQ; Bodymatter, Inc.; LifeRoc Capital, LLC; and their respective affiliates, assigns, and designees (collectively, the "Recipients"; each, a "Recipient"), to facilitate review and/or underwriting by the Recipients of one or more proposed life insurance-related or other transactions with one or more Recipients, which relate to and/or involve the Insured, as well as for all other legal purposes, without limitation.

The undersigned hereby authorizes and instructs [A] any health care provider, not limited to any type or source; [B] each insurer identified in the "Insurer List" below in this Authorization Form (each, an "Insurer"), any affiliate of any Insurer, any reinsurer of any Insurer, and any successor-in-interest of any Insurer and/or of its respective affiliates and reinsurers; [C] any insurance support organization; [D] any consumer, credit, and/or public record reporting agency or entity, including but not limited to LexisNexis, Westlaw, TransUnion, Experian, Equifax, and their respective affiliates; [E] any person authorized to represent any person or entity described by any or all of Items [A] through [D] immediately above, inclusive, for any purpose described in this Authorization Form; and [F] all other persons and entities having knowledge or records of the Insured and/or the diagnosis, treatment, and prognosis with respect to any physical and/or mental condition of the Insured (collectively, the "Authorized Parties"), to release, disclose, and provide to each Recipient, without delay or restriction: [1] any and all individually identifiable health information regarding and/or relating to the Insured, including but not limited to medical records, reports, pharmaceutical and prescription drug records, diagnostic testing, and lab results, including but not limited to such relating to diagnosis or treatment of Human Immunodeficiency Virus, sexually transmitted diseases, and suicidal or mental disorders; [2] all other information concerning the health of the Insured, without limitation; and [3] all other information regarding the Insured as allowed and/or required by applicable law, including but not limited to credit, employment, and consumer background information (items [1], [2], and [3], together, "Insured Information").

For purposes of this Authorization Form, the Insurer List (the "Insurer List") consists of the following insurers:

- **Accordia Life**
- **American General**
- **Ameritas Life**
- **Allianz**
- **American National**
- **Assurity**
- **AXA Equitable**
- **Foresters**
- **Genworth Financial**
- **John Hancock**
- **Lafayette Life**
- **Legal & General**
- **Lincoln National**
- **LSW**
- **MetLife Investors**
- **Minnesota Life**
- **Mutual of Omaha**
- **NACOLAH**
- **Nationwide**
- **New York Life**
- **Penn Mutual**
- **Principal Life Insurance Company**
- **Principal National Life Insurance Company**
- **Protective Life**
- **Prudential Life Insurance Co. of America**
- **Pruco Life Insurance Company**
- **Sagicor Life**
- **SBLI**
- **Symetra Life**
- **Transamerica**
- **VOYA Life**
- **Zurich American Life**
- **VOYA Life**
- **Zurich American Life**

The undersigned acknowledges and agrees that this Authorization Form permits, but does not require, Recipients to seek and obtain Insured Information from any of the Authorized Parties, and that the Recipients shall not be liable for any consequences which follow from any Recipient seeking or not seeking Insured Information, in whole, in part, or otherwise, from any of the Authorized Parties.

This Authorization Form is valid for a period of twenty-four (24) months following the latest date set forth below unless this Authorization Form is validly rescinded by the undersigned prior to the expiration of that time period, provided, however, any otherwise-valid revocation of this Authorization Form is not effective to the extent any person or entity acts in good faith reliance on this Authorization Form. If for any reason the undersigned desires to rescind this Authorization Form, the undersigned may do so in a signed writing clearly indicating that intent, delivered to:

Insurance Marketing Services, Inc.
d/b/a Advisor HQ
19000 MacArthur Boulevard, Suite 450
Irvine, CA 92612

The undersigned further understands that disclosures made pursuant to this Authorization Form may be further disclosed by Recipients to third parties and no longer subject to protection by state, federal, and/or municipal laws, regulations, and rules governing privacy and confidentiality.

The undersigned acknowledges that authorizing disclosure of Insured Information through this Authorization Form is voluntary, that the undersigned can refuse to sign this Authorization Form, and that the undersigned need not sign this Authorization Form in order to assure treatment, payment, enrollment or eligibility for insurance benefits by the Recipients.

By signing this Authorization Form, the undersigned acknowledges and agrees that this Authorization Form is written in plain English, that the undersigned has read and fully understands this Authorization Form in its entirety, that the undersigned has received a copy of this Authorization Form to keep, and that a photocopy or facsimile of this Authorization Form, once completed, signed by the undersigned, and witnessed, is as valid as, and shall be treated as, an original of such signed Authorization Form.

Insured Information	
Print Insured Name:	
Date of Birth:	**Gender:**
Signature:	**Date:**
Authorizing Person Information (signing solely in that capacity)	
Print Name:	
Print Title (if applicable):	
Relation to Insured:	
Signature:	**Date:**