MBG Authorization Form

AIN
AMERICAN GENERAL AMERICAN
NATIONAL ACCORDIA (AVIVIA
LIFE INS. CO.) ASSURITY
AXA EQUITABLE LIFE INS.
BANNER LIFE INS. BRIGHTHOUSE
LIFE INS. CO. BRIGHTHOUSE LIFE
INS CO. OF NY THE CINCINNATI
LIFE INS. CO.
EQUITABLE LIFE
FIDELITY & GUARANTY LIFE
FIRST METLIFE
GENWORTH LIFE INS. CO.
GENWORTH LIFE INS. CO. OF NY
GERBER LIFE
GLOBAL ATLANTIC
JOHN HANCOCK USA
JOHN HANCOCK LIFE
JOHN HANCOCK NY
LINCOLN NATIONAL LIFE INS. CO.
LINCOLN LIFE OF NY
LINCOLN LIFE
LLOYD'S OF LONDON
MASS MUTUAL
METLIFE INVESTORS
METLIFE INS. CO. USA
MINNESOTA LIFE
MUTUAL OF OMAHA
NATIONWIDE
NATIONAL GUARDIAN LIFE
NEW YORK LIFE
NORTH AMERICAN CO. FOR LIFE & HEALTH
NORTH AMERICAN CO. FOR LIFE & HEALTH OF NY
OHIO NATIONAL
ONE AMERICA
PACIFIC LIFE INS. CO.
PACIFIC LIFE & ANNUITY
PENNMUTUAL
PETERSEN INTERNATIONAL UNDERWRITERS
PRINCIPAL LIFE
PRINCIPAL NATIONAL LIFE INS CO.
PRINCIPLE MUTUAL
PROTECTIVE LIFE INS. CO. PROTECTIVE
LIFE & ANNUITY PROTECTIVE LIFE &
ANNUITY OF NY PRUCO LIFE INS.
PRUDENTIAL INS. CO. OF AMERICA
RELIASTAR CORPORATION RELIASTAR
LIFE OF NY
SAGICOR
SECURITY LIFE OF DENVER STANDARD
INSURANCE
STATE LIFE INS. CO.
SYMETRA LIFE INS. CO.
TRANSAMERICA
TRANSAMERICA FINANCIAL LIFE INS. CO.
UNITED OF OMAHA
UNITED STATES LIFE INS. CO. OF NY
UNITED STATES LIFE INS. CO.
VOYA INSURANCE & ANNUITY CO.
WILLIAM PENN LIFE INS.
ZURICH AMERICAN LIFE INS. CO.
ZURICH AMERICAN LIFE INS. CO. OF NY

I (the undersigned) authorize any licensed physician, medical practitioner, nurse, records custodians, hospital, clinic, Pharmacy, Pharmacy Benefit Manager or any other medically related facility, insurance support organizations, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of me or the proposed insured's health, including but not limited to complete medical records in paper or in electronic format, (including information regarding insurance, referral documents, and records from other facilities) to release such information to Millennium Brokerage Group, MBG, MBGI, (the Company) their licensed representatives and/or their reinsurers, insurers, approved vendors, or any other representative to include the life insurance carriers listed above and their affiliates and/or their reinsurance companies.

I understand that information released may include information regarding testing, diagnosis, and/or treatment of communicable diseases. I understand that the information released may include information obtained through my telephonic interview or Personal Health interview. I understand that the information may include information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV). I understand that the information may include diagnosis and treatment of mental illness, but excludes psychotherapy notes, treatment of alcohol, drugs, and tobacco abuse. I understand that the information obtained may be used by the Company to determine eligibility for insurance, or to administer my coverage. The Company may not give the information to any person or entity except: 1) a reinsurer, or other insurer to whom I have applied or may apply; 2) MIB; 3) any other person or entity who performs business or legal services in connection with the application for or administration of my insurance coverage; or 4) the agent and/or agency. I understand that some of these people or entities may not be covered by federal or state privacy regulations and that the information they receive may be re-disclosed, however the Company contractually requires them to protect the information disclosed to them. Information may be disclosed as allowed by law or regulation.

I understand this consent may be revoked in writing to Millennium Brokerage Group, 100 Winners Circle, Ste. 410, Brentwood, TN 37027, at any time, except to the extent: 1) the Company has previously taken action in reliance on this Authorization; or 2) the Company is using this Authorization in connection with a contestable claim regarding my policy. If written revocation is not received, this Authorization will be considered valid for 30 months from the date of signing below.

I understand that if I refuse to sign this Authorization to release my complete medical records in paper or electronic format, that medical treatment cannot be withheld. If I refuse to sign this Authorization, the Company may not be able to process my application for insurance.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this Authorization and that information once disclosed will no longer be protected by the Health Insurance Portability and Accountability Act but will be protected by other applicable federal and state laws relating to the privacy and confidentiality of personal information.

I agree that a copy of the Authorization shall be as valid as the original and that I may have a copy upon request.

_____ _____

Signature or Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient