

Rohrer & Associates

Authorization to Obtain Information/ Waiver and Acknowledgment Form

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 Rohrer & Associates and its agents, employees, and representatives. This includes information on the diagnosis or treatment of AIDS/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 am amending 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 Rohrer & Associates 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 relate to any coverage I have or have applied for with the Insurance Companies named below.

Aetna Life	Cologne Life Reinsurance Co.	Interstate Assurance	Penn Mutual
AIG Life	Colorado Bankers	Jefferson Pilot	Penn Treaty
Allianz	Companion Life	John Hancock	Physicians Mutual
AXA Financial	Coventry Financial	Life of Virginia	Principal Life
AIG/American General	Empire General	Life Settlement Alliance	Protective Life
American Investors	Equitable of Iowa	Lincoln Benefit Life	Prudential
American Life & Casualty	Fidelity & Guarantee	Lincoln National	Rohrer & Associates
American Mayflower	Fidelity Security	Lincoln National Rein. Co.	Security-Connecticut
American National	First Colony	Manulife	SafeCo Life Ins Co./Symetra
AVIVA Life	First Penn Pacific	Mass Mutual	State Life
Banner Life	Fort Dearborn	MONY Life Insurance Co.	Sun Life of Canada
BMA/RBC Life Ins Co	Fortis	Mutual of Omaha	Transamerica
Canada Life	Genworth	NACOLAH	Travelers
Central National	GenAmerica/Met Life	National Guardian	United of Omaha
Citizens Security	Illinois Mutual	New York Life	Union Central
Clarica	ING Reliastar	Old Mutual Financial	West Coast Life
CNA	ING Southland Life	Old Republic	Western Reserve Life
Credit Suisse	ING USG	Pacific Mutual	Met Life Disability

Other Insurance Company: _____

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 for revocation to Rohrer & Associates 158 South Franklin Street, Janesville, WI 53545, Attention: Privacy Official. 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 redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT:

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of Rohrer & Associates, its successors, assigns, shareholders, directors and employees (collectively "R&A").

Applicant acknowledges, understands and agrees as follows:

- that Applicant has filed an application with R&A intending to secure life insurance from one or more insurance underwriters.
- that, in the course of applying for life insurance coverage, R&A 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 R&A will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- that R&A maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- that R&A will use the Interchange to store some or all of the confidential and personal information Applicant has provided to R&A, 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 R&A has in place security measures R&A believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though R&A will continue to upgrade those security measures from time to time as circumstances warrant, R&A can make no guarantee as to R&A's ability to protect the Interchange and the 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 Interchange.
- that R&A cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is 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 R&A's possession and/or stored on the Interchange.
- that Applicant will indemnify R&A for all costs and expenses incurred by R&A or any of its employees, shareholders, directors, agents or representatives 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:** _____

X _____
Signature of Proposed Insured/Parent or Guardian

X _____
Signature of Witness

Printed name of Proposed Insured/Parent or Guardian