FIRST FINANCIAL RESOURCES

800 SOUTH STREET, SUITE 455
WALTHAM, MA 02453

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

(THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE)

--This is not an application for insurance--

I understand that the below noted life insurance companies ("Companies") to which I apply, their reinsures, support organizations, and their representatives will need information about me with regard to proposed insurance underwriting.

I authorize any licensed physician, medical practitioner, hospital, clinic, other health care providers that have provided treatment or services to me ("My Providers"), insurance companies or the Medical Information Bureau ("MIB"), or other organization(s) to provide information regarding my mental and physical health to the Companies and/or their authorized agents to determine my eligibility for insurance coverage. 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.

By signing below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction.

This authorization shall be valid for two (2) years after the date on which it is signed by me, and a copy of this authorization is as valid as the original. I may request a copy of this form at any time.

I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to First Financial Resources, 800 South Street, Suite 455, Waltham, MA 02453-1433. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information. However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand and acknowledge that I will receive or have received a copy of this authorization.

______________________________   ____________________

Insured's Signature   Dated

Insured's Name: ______________________________

Address: ______________________________

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DOB: ______________________________

SS#: ______________________________

AIG Life Insurance Co.	First Penn Pacific	Jackson National	MONY / AXA	Sun Life of Canada	US Financial
American General Life	GE Capital Assurance	Jefferson Pilot	New England	State Life	United States Life
Ashar Group	General American	John Hancock	No. America Co L&H	Transamerica	West Coast Life
Banner Life	Hartford Life	Lincoln Benefit	Pacific Life	Travelers	
CNA/Valley Forge	Indianapolis Life	Lincoln Life	Petersen Int'l Underwriters	UNUM	FFR – Waltham c/o
Coventry First	ING Reliastar	Maple Financial	Phoenix Home Life	United of Omaha	David M. Isaacson
Empire General	ING Security CT	Mass Mutual	Principal	USG Annuity	
F&G Annuity	ING Sec Life Denver	Metropolitan Life	Prudential		
First Colony Life	ING Southland	Midland	SBLI	New First Financial Resources, LLC	