HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT ("HIPAA")
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Patient / Proposed Insured (Please Print)_____

Date of Birth _____

I, hereby, authorize all of the people and organizations listed below to give The Cason Group, Inc., and their authorized representatives, including agents and insurance support organizations, including but not limited to RSA Medical, the following information:

Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments or surgeries, hospital confinements for physical and mental conditions, use of drugs or alcohol, prescription records and history of medications prescribed and communicable diseases including HIV or AIDS

I, hereby, authorize each of the following entities to provide the information listed above:

- Any physician or medical practitioner
- Any hospital, clinic or other health care facility
- Any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage)
- Any consumer reporting agency or insurance support organization
- My employer, group policy holder or benefit plan administrator
- The Medical Information Bureau (MIB)

I understand that the information obtained will be used by the recipient to:

- Determine my eligibility for insurance
- Underwrite my application for insurance
- Determine my eligibility for benefits under any temporary insurance
- If a policy is issued, determine my eligibility for benefits and contestability of the policy

I, hereby, acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the recipient will be used and disclosed as described in the General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: The Cason Group, Inc. 1612 Marion St. Columbia, SC 29201. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary. However, if I do not sign the authorization, the Companies many not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Proposed Insured or
Proposed Insured's Personal Representative Date

Description of Authority of Personal Representative
(If Applicable)

NOTICE OF EXCHANGE OF INFORMATION & FAIR CREDIT REPORTING ACT NOTICE

The information regarding your insurability will be treated as confidential. However, the life insurance companies listed on this form, or its reinsurers, at the time of your signature, may make a brief report to the Medical Information Board, a nonprofit membership organization of life insurance companies, which operates an information exchange for its members. If you apply for life or health insurance to another company, which is also a member of the Bureau, or, if a claim for benefits is submitted to such a company, the Bureau, will, upon request, supply the information on this file to that company. The life insurance companies listed on this form or its reinsurers, at the time of your signature, may also release information in its file including information given in your application to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician). If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is PO Box 105, Essex Station, Boston, MA 02112, Telephone: 617-426-3660.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

I, hereby, authorize any licensed physician, medical practitioner, psychotherapist, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health or treatment, to give The Cason Group, Inc. any such information. The information, which may be disclosed includes records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, prescription records and history of medications, character habits, avocations, finances, general reputation, credit or other personal traits.

To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency or investigative company employed by The Cason Group, Inc., including but not limited to RSA Medical, to collect and transmit such information. I further authorize The Cason Group, Inc. to prepare or obtain an investigative consumer report in connection with this application.

The life insurance companies listed on this form or its reinsures, at the time of your signature may secure personal interviews with third parties such as family members, business associates, financial sources, friends or others with whom you are acquainted concerning your character, general reputation, person characteristics and mode of living. Upon written request, additional information will be provided as to the nature and scope of the report, if one is made.

AIG/American General
ALLIANZ Life
Americom
Americo
American National
Amerus
Assurity Life
Banner Life/LGA
Bankers Life of NY
Brighthouse
Chase
Chesapeake Life
Cincinnati Life
Coventry First
Empire General
Fidelity & Guaranty
First Penn Pacific
General American
Genworth
Guaranteed Trust Life
Illinois Mutual
Indianapolis Life
ING Reliastar
Jefferson National
Jefferson Pilot
John Hancock
Life Settlement Alliance
Lincoln Benefit
Lincoln Financial Group
Manulife
Mass Mutual
MET Life Investors
Mutual of Omaha
Nationwide
North American Co for L&H
OneAmerica
Petersen International
Presidential Life
Principal National Life Ins. Co
Principal Life Ins. Co
Protective Life
Prudential Life
Reliastar Life of NY
RGA
Secured Financial Group
Securian
Security Mutual Life
Sun Life Financial
The Standard
Transamerica Ins. & Invest.
Transamerica of NY
Transamerica Travelers U.S.
Financial Voya
West Coast Life
William Penn

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

DOB

SSN