



**POLICY APPRAISAL REQUEST FORM**

**Insured Information**

Insured Name(s)		Date of Birth
Address		Social Security #
City	State	Zip

Marital Status: <input type="checkbox"/> Single/Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	Are you a defendant in any suits or legal actions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been declared bankrupt? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**Please complete the following and check your preferred method of communication.**

<input type="checkbox"/> Phone Number 1	<input type="checkbox"/> Phone Number 2	<input type="checkbox"/> Email Address
<input type="checkbox"/> Personal Representative/Financial Professional (If applicable, include Name and Phone Number)		

**Life Insurance Policy Information**

Policy Owner, if not Insured	Insurance Company	Policy Number
Policy Face Value	Date of Issue	Premium Amount & Frequency
Policy Type: <input type="checkbox"/> UL <input type="checkbox"/> Term <input type="checkbox"/> Whole <input type="checkbox"/> Joint <input type="checkbox"/> Other	Was this policy converted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, conversion date and type:	

**Medical Information**

Brief Medical History
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**Please provide contact information for your physicians and/or hospitals. For additional health care providers, please provide an additional sheet.**

Name	Phone Number	Fax Number
Name	Phone Number	Fax Number

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison. The applicant warrants and represents that all information contained in this application is true and correct to the best of his/her knowledge. (v4.3)

*Toll Free Office Line: 888.235.0753 ♦ 2160 Woodcrest Drive ♦ Green Bay, WI 54304  
Fax: 920.490.7933 ♦ www.LifeInsuranceForLife.com ♦ support@lifeinsuranceforlife.com*



**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide SBA and/or its authorized representative or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders, and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or competing the sale of life insurance policy(ies) on which I am the owner and Insured, and I hereby expressly authorize such use and disclosure. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Signature of Policy Owner-if other than insured

\_\_\_\_\_  
Printed Name of Insured                      Date

\_\_\_\_\_  
Printed Name of Policy Owner                      Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed Name of Witness                      Date

\_\_\_\_\_  
Printed Name of Witness                      Date

**AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, the undersigned, authorize disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:

1.Classes of Persons Authorized to Disclose My Protected Health Information: I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, and any other type of health care provider (each, an "HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2.Classes of Persons Authorized to Receive My Protected Health Information: I authorize each Authorized HCP to disclose my PHI under this authorization to Life Insurance For Life and/or its authorized representative or designees, and of its affiliates and any of their directors, officers, employees, agents, independent contractors, consultants, medical underwriters, lenders, financing entities, stop-loss reinsurers, service providers or other representatives (each, an "Authorized Recipient").

3.Protected Health Information Authorized for Disclosure and Purpose of Disclosure: This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations. This authorization and all disclosures of my PHI made under this authorization are for purposes of allowing the Authorized Recipient (1) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to the Authorized Recipient and (2) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that Life Insurance For Life and/or its authorized representative or designees,

4.Expiration: This authorization shall remain valid until, and shall expire, one year after the date of my death.

5.Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6.Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. No HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

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Signature of Insured

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Printed Name of Insured                      Date

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Signature of Personal Representative of Individual (If Applicable)

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Description of Personal Representative's Authority (Power of attorney, Guardian ad Litem or similar status)