

## Trial APP

Full Name	SS#	Face Amount \$	Planned Premium	Term _____ UL _____
Address	Male _____ Female _____	Smoker _____ Non-smoker _____ Tobacco in what form?		Date of Birth
For how much are you insured? Company	Amount of Insurance	Year Issued	Type of Insurance	
_____	\$ _____	_____	_____	
_____	\$ _____	_____	_____	
_____	\$ _____	_____	_____	
Medical Problems	Doctors or Hospitals - Full Address	Dates Seen	Treatment and Results	
Height _____ feet _____ inches	Weight _____ lbs.	Other pertinent information: (Attach separate sheet if necessary)		

Name of Company

\_\_\_\_\_

\_\_\_\_\_

**Detail of Previous Application or Inquiries to Other Companies**

Amount Applied For:

\$ \_\_\_\_\_

\$ \_\_\_\_\_

Other Company's Underwriting Action:

\_\_\_\_\_

\_\_\_\_\_

**Authorization for Release of Health-Related Information to  
Premier Brokerage Services and Its Carriers**  
This Authorization complies with the HIPAA Privacy Rule

\_\_\_\_\_  
Name of proposed insured/patient (please print)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, insurance company, insurance support organization, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Premier Brokerage Services, Inc. ("The Company") and its agents, employees, representatives and carriers. 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, but excludes psychotherapy notes.

By signing below, I terminate 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.

My protected health information is to be disclosed under the Authorization so that the Company may: 1) provide information to carriers so the carriers may underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the 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 the Company at 604 Harper Avenue, Jenkintown, PA 19046, Attention HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is 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 (such as the HIPAA Privacy Rule).

I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative Date

\_\_\_\_\_  
Signature of Secondary Proposed Insured/Patient or Personal Representative Date

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

SS# of Primary Insured/Patient \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
SS# of Secondary Insured/Patient: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

Address: \_\_\_\_\_  
Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Agent's Name \_\_\_\_\_ Phone Number: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
FAX: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_