

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, health plan, medical practitioner, medical care provider, psychologist, chiropractor, physical therapist, hospital, nursing home, mental health facility, rehabilitation or ambulatory care center, medical clinic, laboratory, pharmacy, Pharmacy Benefit Manager, treatment facility, insurer, insurance support organization, service provider, Kaiser Permanente, financial institution, consumer credit reporting agency, certified public accountants and tax preparers, educational institution, Federal, State, or Local Governmental Agency, including the Social Security Administration, Veterans Administration, or Workers Compensation Board, an authorized medical officer of a United States Government facility, law enforcement agencies, state and local tax agencies, or other medical or medically related facility, specifically including those persons/organizations listed above, to give or disclose my entire medical record and any other protected health information, or other personal, private, or privileged information concerning me for the past 10 years to Advisors Financial Group (AFG), Insurance Designers of America (IDA), the insurance companies listed below (and their affiliated companies), its agents, employees, vendors or representatives.

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| Abacus Settlements, LLC | National Western Life Insurance Company |
| AIG/American General Life | Nationwide Mutual Insurance Company |
| Allianz Life Insurance Company | New York Life Insurance Company |
| American National Life Insurance Company | North American Company for Life and Health Insurance |
| Ameritas Life Insurance Corporation | One America Company |
| Assurity Life Insurance Company | Oxford Life Insurance Company |
| Banner Life Insurance Company | Pacific Life Insurance Company |
| Columbus Life Insurance Company | Penn Mutual Life Insurance Company |
| Equitable Life Insurance Company | Principal Life Insurance Company |
| Gerber Life Insurance Company | Protective Life Insurance Company |
| Global Atlantic Financial Group | Prudential Insurance Company of America |
| Habersham Funding | Savings Bank Life Insurance Company |
| John Hancock Life Insurance | Securian Financial Group |
| Lafayette Life Insurance Company | Standard Insurance Company |
| Lincoln National Insurance Company | State Life Insurance Company |
| Longevity Quest | Symetra Life Insurance Company |
| Minnesota Life Insurance Company | Transamerica Life Insurance Company |
| Mutual of Omaha Insurance Company | United of Omaha Life Insurance Company |
| National Guardian Life Insurance Company | Welcome Funds |
| National Life Group | Zurich Life Insurance Company |

I authorize the disclosure of any and all records and information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition are to be released, including information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, ARC (Aids-Related Complex) or AIDS, and sexually transmitted diseases and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco; employment information and history, including job duties, earnings, personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, finances, tax records, and bank records; business transactions including billing, invoice, and payment records; academic transcripts; law enforcement court and military records; and information concerning Social Security benefits, or other disability or workers' compensation benefits, including monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. Such information shall be referred to herein collectively as "My Information".

My Information is to be disclosed under this authorization so that AFG and IDA may underwrite any insurance I am or will be applying for through the above-mentioned companies, make an insurance eligibility determination and ascertain a potential risk rating. This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter duration.

I understand and acknowledge that any agreements I have made to restrict My Information, including protected health information, do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider, or other entity to release and disclose My Information, including my entire medical record, without restriction.

I understand that I have the right to refuse to sign or to revoke this authorization in writing, at any time, by sending a written request for revocation to Advisors Financial Group at 5904 Six Forks Road, Suite 105 Raleigh, NC 27609, Attention Privacy Official. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that an insurance company has taken action in reliance on this Authorization or has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. I understand that if I refuse to sign, alter, or revoke this Authorization AFG and IDA may not be able to process my Underwriting Appraisal. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured / Patient

Date of Birth

Last 4 Digits of SSN

Printed Name

Advisor Name

Date