New Application Submission

North Central DI

Advisor to Complete

Insured's Name: _____ Date: _____

Producer's Name: _____ Phone: _____

Contact for case updates: _____ Phone: _____

Sales illustration:

- ☐ Yes, an illustration for the desired plan design is attached (illustrations are required for all applications)

Other DI coverage (in-force or pending):

- ☐ Client has no other Individual DI or Group LTD coverage in-force or pending
- ☐ Other coverage (full details listed on app) will be placed / retained
- ☐ Other coverage (full details listed on app) will be replaced

Income documentation:

- ☐ Attached
- ☐ Will follow
- ☐ N/A - applying for professional limits or via special underwriting program

Discount info:

- ☐ Yes - application lists appropriate discount name and number
  If a "look back" discount, date client departed listed program: _____
- ☐ N/A - this client is not eligible for any special discounts

If client is a physician, please complete:

Medical Specialty: _____

Physician career phase:

- ☐ Resident / Fellow
- ☐ Within 180 days of graduating & starting practice. Graduation date: _____
- ☐ Practicing physician

Additional comments / special instructions:

Advisor/Assistant or Processor to Complete

Medical Requirements:

- ☐ NorthCentral DI, please determine & order; no other Life/DI/LTC apps are pending or planned
- ☐ Copy of client's recent medicals (lab slip and, if applicable, Paramed exam) attached
- ☐ Agent's office has ordered and will provide copies of (please check all that apply):
  - ☐ Blood / UA
  - ☐ Paramed exam **or** (select one only)
    - ☐ Physical measurements (aka "simple" or "mini exam")
  - ☐ EKG

Reset Form

HIPAA COMPLIANT AUTHORIZATION
TO DISCLOSE PROTECTED HEALTH INFORMATION

PDC CASE # _____

Patient Name _____ Health Record Number _____
Date of Birth _____ Social Security Number _____

1. Records and information obtained will be disclosed to:_____
   Insurance Company Name Here
2. The following individual or organization is authorized to make the disclosure

   _____

   Address _____

3. The type and amount of information to be used or disclosed is as follows:

   - ☐ Problem list
   - ☐ Medication list
   - ☐ List of allergies
   - ☐ Immunization record
   - ☐ Most recent history and physical
   - ☐ Most recent discharge summary
   - ☐ Laboratory results *From (date)*_____ *to (date)* _____
   - ☐ X-ray and imaging reports *From (date)*_____ to *(date)* _____
   - ☐ Consultation reports *From* (doctors' *names)* _____
   - ☑ Entire record
   - ☐ Other _____ Complete PHI from _____ to _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed and exchanged between the insurance company named above, and:

PDC RETRIEVALS
Po Box 150356
Kew Gardens, NY 11415
877-516-1476

For the purpose of: Insurance

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to PDC Retrievals. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:
   One year from date of signature
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1 64.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the entity listed in item number two on the first page of this form.

X

Signature of Patient or Legal Representative Date

If Signed by Legal Representative, Relationship to Patient

X

Signature of Witness Date

A copy of this form may be valid as the original unless specified otherwise.

Note: The type of documents listed on the authorization form above may need to be modified depending on the particular health setting. Condition specific forms should be developed for research, or when a covered entity is seeking information for which it will be remunerated, etc.

AUTHORIZATION TO OBTAIN AND DISCLOSE PERSONAL INFORMATION

I understand that the life and disability insurance companies named below, their reinsurers, any insurance support organizations, and the representatives of these companies may, as a direct result of my insurance application(s) to said carrier(s), collect personal medical, financial, and employment information about me.

For purposes of this authorization, medical information includes all medical records and health information pertaining to any medical history or physical condition and treatment received including, but not be limited to, patient histories, progress and claim notes, test results, X-ray/laboratory and other reports, psychiatric evaluations, drug and/or Alcohol Treatment, information and/or HIV Tests/Test Results, and any other pertinent medical information.

For purposes of this authorization, financial information includes federal and state tax returns and schedules, payroll documents, financial statements, W-2 and 1099 statements, and any other pertinent employment or income information, financial information or documentation.

I authorize all insurance industry entities noted above and listed below to release all records, documents, information and knowledge to NorthCentral DI, its authorized agents, employees, or representatives for the purpose of medical and financial insurance underwriting.

Additionally, I understand and agree that NorthCentral DI may disclose my medical and financial records, and the information contained in those records, to other insurance companies to which I have applied or may apply, reinsurance companies, or other persons or organizations performing business, professional, or insurance functions for the purpose as stated above. Medical or financial information, as it affects my insurability, may also be discussed with my insurance agent, his/her agency employees and authorized representatives. I also understand that when disclosed pursuant to this Authorization, my medical and financial records and the information contained in those records may be subject to re-disclosure by the recipient and may no longer be protected by Federal Privacy Laws.

This authorization will remain in effect for 12 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I may revoke this Authorization, except to the extent that any action has been taken in reliance upon it. My revocation of this Authorization must be in writing to NorthCentral DI.

Print Name _____ Date of Birth: _____

Signature _____ Date: _____

Ameritas Life Ins. Corp.
Ameritas Life Ins. Corp. of NY
Assurity Life Insurance Company
Berkshire Life Ins. Co.
Fidelity Life
Guardian Life Ins. Co.
Illinois Mutual
Lloyds of London
MassMutual Life Ins. Co.
MetLife
Mutual of Omaha
Petersen International Underwriters
Principal Life Insurance Company
Risk and Reinsurance Solutions
The Standard