



INFORMAL INQUIRY AUTHORIZATION FOR DISCLOSURE - HIPAA COMPLIANT

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, pharmacy benefit managers, insurance support organizations, hospital, clinic and/or any other health care provider ("Authorized Disclosure") to provide to Madison Brokerage Corp. and/or its affiliates, directors, officers, employees, service providers or other representatives noted below ("Madison Brokerage Corp."), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Disclosure to release to Madison Brokerage Corp. the results of any HIV or AIDS test as well as information relating to any sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/ or information.

I understand that all medical information disclosed here under will be treated as confidential and will only be used by Madison Brokerage Corp. in connection with the decision to purchase, finance, transact a life settlement and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

I understand I have the right to revoke this Authorization in writing at any time, by sending a written request of revocation to: Madison Brokerage, 65 Madison Avenue, Suite 200, PO Box 1940 Morristown, NJ 07962-1940. I understand that this revocation is not effective to the extent that (i) the Authorized Disclosure has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care clearing house or health plan covered by 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, any of my medical information disclosed by any Authorized Disclosure to Madison Brokerage Corp. may be redisclosed by Madison Brokerage Corp. to the following recipient parties: other insurers to which the Proposed Insured has applied or may apply; reinsurers; MIB; or persons or organizations that perform business, professional, or insurance tasks for them. I also understand that some information may be disclosed to persons or organizations that are not subject to federal health information privacy laws, which means that the information may no longer be protected under such laws. But even if information is disclosed to persons or organizations that are not subject to federal health information privacy laws, those persons or organizations must comply with all other applicable legal requirements governing the protection and redisclosure of information.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained herein is true, accurate and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a signed copy of this Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Disclosure to rely upon a photo static or facsimile copy or other reproduction of this Authorization the same as the original.

This Authorization shall remain valid until, and shall expire 36 months from the signature date.

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Name of Insured: _____

Signature: _____

Date of Birth: _____

Social Security Number: _____

Date: _____