5957 Freeport Boulevard
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HIPPA AUTHORIZATION

Name of Proposed Insured/Patient (Print) ______________________ Date of Birth ______________________

Name of Witness (Print) ______________________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit 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 or to or on the behalf of my unemancipated minor children ("My Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to the company(ies) referenced on this authorization ("the Company(ies") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. I authorize the company(ies) to release any such information to reinsuring companies, or other persons or organizations performing business or legal service for the company(ies). This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, including psychotherapy notes. This authorization is given for the purpose of determining whether I am eligible to participate in an insurance or life settlement transaction.

By my signature below, I acknowledge that any agreement I have made to restrict my protected health information or that of my unemacipated minor children does not apply to this authorization and I instruct My Provider to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508 (c) (1) (iv) of the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule. 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 anytime, by sending a written request for revocation to Nexus Solutions, Inc., 5957 Freeport Blvd, Sacramento, CA, 95822, Attention: HIPPA 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 to the extent that any of My Providers has relied on this Authorization or to the extent that the Company(ies) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer by protected by federal regulations governing privacy and confidentiality of health information (such as the HIPPA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company(ies) 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 ______________________ Date (mm/dd/yr) ______________________

Signature of Witness ______________________ Date (mm/dd/yr) ______________________

Social Security Number of Primary Insured/Patient ______________________

Address ______________________ City State Zip ______________________