Fax: 614-718-9903

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 Problem	Doctors or Hospitals - Full Address	Dates Seen	Treatment and Results

Height ___feet___ inches	Weight _______	**Other pertinent information: (Attach separate sheet if necessary)**

Details of Previous Applications or Inquiries to Other Companies

Name of Company	Amount Applief For	Other Company's Underwriting Action:
________________________________	$ ____________	____
________________________________	$ ____________	____

(This is a two page document - please complete both pages in full)

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize the Rucker Insurance Agency LLC and its affiliated agencies, including but not limited to RSA Medical, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, including but not limited to RSA Medical, insurance companies and their reinsurers. 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, prescription records and history of medications prescribed, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Rucker Insurance Agency LLC. 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.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their reinsurers as well as Rucker Insurance Agency LLC and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Rucker Insurance Agency LLC may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

________________________________	________________________________
Proposed Insured's Name	**Proposed Insured's Signature**
________________________________	________________________________
Signed and Dated On	**At (City, State, Zip Code)**

Agent/ Witness ________________________________

AIG, American General Life Insurance Company, American National Insurance Companies, Aviva Life, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, ING USA Annuity and Life Insurance Company, John Hancock, Lincoln Benefit Life, Lincoln National Life, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Security Life of Denver Insurance Company, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, West Coast Life, William Penn Life Insurance Company of New York