gentrypartners ltd.

BOUTIQUE BROKERAGE HOUSE

HIPAA Authorization

Health Insurance Portability and Accountability Act

v01112023

Insured: _____ **Date of Birth:** _____ **Social Security #:** _____

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") as defined under the applicable privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as follows:

1) Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, physician, physician practice group, laboratory, Pharmacy Benefit Managers, and any other type of health care provider, health care clearinghouse and healthcare plan (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

2) Classes of Persons Authorized to Receive My Protected Health Information. I authorize each Authorized HCP to disclose my PHI under this authorization to Gentry Partners/and/or represented insurance carriers/affiliates/reinsurers, as well as life settlement providers/syndicates/brokers/ purchasers/financers listed below, including any of their successors (potential and actual), assigns and affiliates and any of their respective directors, officers, employees, agents, independent contractors, service providers, accountants, actuaries, attorneys and other representatives and advisors, (each, an "Authorized Recipient"). I also authorize each Authorized Recipient to share the information described herein with potential and actual counterparties (and affiliates) to financing, hedging and related arrangements, and such counterparties' respective directors, officers, employees, agents, independent contractors, service providers, accountants, actuaries, attorneys, other representatives.

3) Description of Protected Health Information Authorized for Disclosure and Purpose of Disclosure. This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, in connection with the possible sale of any life insurance policy, or certificate of life insurance, under which my life is insured to any Authorized Recipient and (b) to monitor, track or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured that any Authorized Recipient purchases.

4) Expiration of Authorization. This authorization shall remain valid until, and shall expire, two (2) years from the date hereof.

5) Right to Revoke Authorization. I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

6) Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization. I understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to HIPAA (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Insured Signature: _____ **Date:** _____

AIG
American General
Accordia Life
Banner Life
Brighthouse Financial
Equitable
First Colony
First Penn
Global Atlantic
Hartford
Jackson National
John Hancock
Lincoln National Life
Manulife
Mass Mutual
Milliman, Inc.
Minnesota Life
Mutual of Omaha
National Life
Nationwide
New York Life
North American
Northwestern Mutual
One America
Pacific Life
Penn Mutual
Principal Life Insurance Co.
Protective Life
Prudential
Securian Life
Security Life of Denver
Sun Life
Symetra
Talcott Resolution Life
Transamerica
United of Omaha
UNUM
Voya Financial
Zurich American