HUNTER
McCORQUODALE
INSIGHT • INNOVATION • INTEGRITY

AUTHORIZATION TO DISCLOSE INFORMATION TO MY ADVISOR

Important: This authorization is optional - We do not need it in order to review and make a decision about your application.

Proposed Life Insured

In this form, "you" and "your" refer to the Proposed Life Insured. "We", "us", "our" and "The Company" refer to Hunter McCorquodale and/or its authorized representatives.

Name _____ _____ _____
First Name Initial Last Name

Date of Birth _____ ☐ Male ☐ Female Smoker ☐ Yes ☐ No
DD/MM/YYYY

Advisor Information

Advisor Full Name _____

Advisor Designated Affiliate (if applicable) _____

Purpose of this Authorization

If you sign this form, you give us permission to discuss your personal (including medical) information with your advisor or designated affiliate listed above. These individuals may use it to discuss insurance options and explain underwriting decisions with you.

Authorization

By signing below, you authorize the company to discuss information about you, which was collected on the application number set out above. The information about you that we may discuss with your advisor or designated affiliate can include:

1. Medical testing and laboratory results;
2. Confidential personal information about illness, including mental illness, other medical conditions, use of medication, drug or alcohol use and rehabilitation;
3. Other information about your health discovered as we assess your application but that you may not know about when you apply;
4. Employment history and personal finances;
5. Any record of criminal activity; and
6. Other facts about your life and how they affect our decision to insure you.

*We reserve the right to not share all sensitive medical/financial information.

By signing this for, you agree:

1. You have read and understood the purpose of this authorization;
2. You are authorizing us to discuss information, set out in this form, to your advisor or designated affiliate;
3. Even though you have signed this form, we have the right to withhold highly sensitive personal information from your advisor or designated affiliate;
4. You may rescind the Authorization by notification in writing to The Company at any time;
5. You understand that this authorization remains valid until 30 days after the later of the day we:
    a. Issue a new insurance policy or amend an existing insurance policy; or
    b. We mail you a notice telling you that we have declined your application.

Applicant Signature _____ **Date** _____
DD/MM/YYYY