900 Veterans Memorial Blvd., Metairie, LA. 70005 Phone: (504) 837-2300
Fax to: Ashley Fleischer (504) 837-0090 or E-Mail: ashley@hancockbrokerage.net

TRIAL APPLICATION

Full Name	SS#	Face Amount $	Planned Premium $	Term_____ UL _____
Address Occupation:	Male _____ Female _____	Smoker _____ Non- Smoker _____ Tobacco in what form? pipes, cigars, chewing tobacco, nicotine gum, patch How often: _____		Date of Birth _____

Current Insurance Inforce/Company	Amount of Insurance	Year Issued	Type of Insurance
_____	$_____	_____	_____
_____	$_____	_____	_____

Medical Condition	Doctors or Hospitals - Full Name, address and phone numbers	Date Seen	Treatment and Results LIST MEDICATIONS
LIST MEDICATIONS and DOSAGE:			

Height____Feet___ Inches	Weight_____Lbs.	Other pertinent information: (Attach separate sheet if necessary)

Details of Previous Applications or Inquiries to Other Companies

Name of Company	Amount applied For	Other Company's Underwriting Action:
_____	$_____	_____
_____	$_____	_____

Authorization for Release of Health-Related Information to Hancock Brokerage LLC and Its Carriers

This authorization complies with the HIPAA Privacy Rule

_____ _____/_____/_____

Name of proposed insured/patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits 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 ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Hancock Brokerage LLC(" the Company") and its agents, employees, representatives and carriers. 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, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under the Authorization so that the Company may:1(provide information to carriers so the carriers may underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24months 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 any time, by sending a written request for revocation to the Company at

Hancock Brokerage, LLC, 900 Veterans Memorial Blvd, Metairie, LA 70005, Attention: HIPPAA 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 if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under any insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule).

I understand that if I refuse to sign this authorization, the Company 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.

_____ Date_____

Signature of ***Proposed Insured/Patient*** or Personal Representative

_____Date _____

Signature of ***Secondary Proposed Insured/ Patient*** or Personal Representative

_____ Date _____

Description of Personal Representative's Authority or Relationship to Proposed Insured/ Patient

_____

SS# of Primary Insured/ Patient: _____-_____-_____ SS# of Secondary Insured/Patient: _____-_____-_____

Address: _____ Address: _____

_____ _____

Transamerica Life	Met Life	Minnesota Life	AIG/American General	New York Life
Banner Life/Legal & General	Protective	Lincoln Financial	Prudential	Assurity
North American	United of Omaha	John Hancock	Mass Mutual	AXA
Genworth Financial	Nationwide	VOYA	Global Atlantic	Guardian Life
United Home Life	Guarantee Trust	American National	Principal Life	Ameritas
Coventry	Zurich Life	Welcome Funds	Symetra	Ohio National
National Life- LSW	Peterson International		National Western	Penn Mutual

Agent's Name _____ **Phone Number (____)** _____-_____ **Fax Number (___)** ____- _____

E-MAIL:_____ **Page 2 of 2** **Revised 06/09/2016**