900 Veterans Memorial Blvd., Metairie, LA 70005 (504) 837-2300
Fax to: Ashley Fleischer (504) 837-0090
or email: 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 Actions
______________________	$_____________	_________________________________
______________________	$_____________	_________________________________

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 that 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 I have or have applied for with the Company.

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 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 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:____

Abacus	Coventry	Life Equity	Nationwide	Q Capital
AIG/American General	Equitable	Lincoln Financial	North American	Sagicor
American National	Genworth	Magna	One America	SBLI
Assurity	Global Atlantic	Maple	Pacific Life	Symetra
Banner Life/Legal	Guardian Life	Minnesota Life	Peterson International	Transamerica
Brighthouse (Met Life)	ILS	National Life-LSW	Principal Life	United of Omaha
Cincinnati Life	John Hancock	National Western	Protective	Voya
			Prudential	Life Settlement Providers

Agent's Name:_____________________________________**Phone#**_________________________**Fax#**________________

E-MAIL:____

Revised 6.5.20