The ASA Group

Enhancing the Producer Experience

A Corporation's Guide to the Insurance Review Program

In order to complete the review program, the following items must be completed and faxed to: 501.400.8578

Steps to complete the program:

1. Complete the following information about the Agent.

Name of agent submitting review: _____

Agent phone number: _____

Agent email address: _____

2. Please confirm the type of policy. Provide a copy of the last annual statement and inforce illustrations, if available.

IUL ☐	VUL ☐	UL ☐	WL ☐	Term ☐	Unknown ☐

3. Please confirm the current premium being paid.

Amount: $ _____

3A. Premium Mode:

Annual ☐	Semi-Annual ☐	Quarterly ☐	Monthly ☐

4. Please provide a copy of the ASA Authorization. An ASA Authorization form will need to be completed on every policy. If the existing carrier is listed below, complete the carrier specific form in addition to the ASA Authorization.

All State	**American Fidelity**	**Athene - Aviva**	**AXA**	**CNA**
Conseco	**Fidelity Life Association**	**Jackson National**	**Lincoln National**	**Mass Mutual**
Ohio National	**Provident**	**Principal Financial Group**	**Phoenix Life**	**Pacific Life**
USAA	**Security Mutual**	**Reassure America**	**Penn Mutual Life**	

5. Set proper expectations about the timeliness of the policy review program. To ensure the review is handled expeditiously please complete all forms as thoroughly as possible and return to The ASA Group. Responsiveness of the existing carrier will also play a primary role in the timeliness of completing the review process. Most policy reviews can be completed in as little as 3 weeks, but there is potential for the process to take as long as 12 weeks.

6. You may email these documents to PHS@theasagroup.com, or submit them via fax, 501.400.8578. You will be notified once we have received your submission.

The ASA Group
Review Department
11807 Hinson Rd, Little Rock, AR 72212
Phone: 501-224-7739
Email: PHS@theasagroup.com
Fax: 501-400-8578

Authorization to Release Information

Carrier Name:_____		Policy Number:_____	
1st Insured Name: _____		2nd Insured Name: _____	
SSN: _____		SSN: _____	
DOB: _____	Male ◯ Female ◯	DOB: _____	Male Female

A photocopy of this document shall be as valid as the original.

By my signature below, I hereby authorize the above insurance carrier to release any and all information requested on this policy to Danielle Burns or Luke Ramsey. This shall include, but not limited to: a copy of the complete life insurance contract, the application for issuance, copies of annual statements and other policy change documents, the as sold illustration, current illustrations, and completed policy review questionnaire including current values.

In addition, the insurance carrier's representatives are authorized to discuss the above referenced policy with Danielle Burns or Luke Ramsey. This form does not authorize Danielle Burns or Luke Ramsey to exercise any other rights of policy ownership. The information released under this authorization shall be sent directly to Danielle Burns or Luke Ramsey.

This Authorization shall remain valid for the maximum period allowed under applicable state laws, unless and until such time as I advise the insurance carrier in writing of its' revocation.

Corp. name: _____	Corp Tax ID#: _____
Officer name: _____	Officer title: _____
Officer signature: _____	Date: _____
Witness signature: _____	Date: _____

Please submit to:

The ASA Group
Review Department
11807 Hinson Rd, Little Rock, AR 72212
Phone: 501-224-7739
Email: PHS@theasagroup.com
Fax: 501-400-8578

Request to Release Information to a Non-Owner

Allstate Life Insurance Company
P.O. Box 660191, Dallas, TX 75266-0191
Telephone: (Fixed Life) 1-800-366-1411
(Fixed Annuity) 1-800-632-3492
Fax: (Fixed Life) 1-877-255-1329
(Fixed Annuity) 1-877-525-2689

The purpose of this form is to provide permanent authorization to an individual, or individuals, to obtain policy information.

Step 1 - Policy/Contract Information (All fields must be completed) - Only one policy per form, please submit a separate form for each policy.

Owner's Name	Policy/Contract Number ☐☐☐☐☐☐☐☐☐☐
Owner's Phone Number	Insured's or Annuitant's Name

Step 2 - Releasing Information - If more than five authorized individuals, please use a separate sheet of paper to list the names and attach to this form. If the owner of the policy is not an individual, please put the names on the owner's letterhead.

Danielle Burns / Luke Ramsey

Please print the name(s) of each authorized individual

Check all that apply*

☑ Any authorized individual, when calling by phone, is permitted to receive my policy information verbally.

☑ Any authorized individual, when calling by phone, is permitted to receive my policy information in written form.

☑ Any authorized individual, when submitting a written request, is permitted to receive my policy information.**

* This authorization can only be rescinded by the owner in writing.

** Please ensure that all authorized individuals sign on the appropriate signature line at the bottom of the form or next to their printed name on an attached sheet.

AXA EQUITABLE

redefining / standards®

AXA Equitable Life Insurance Company
MONY Life Insurance Company of America
AXA Life and Annuity Company

Life Insurance

Third-Party Release of Life Insurance Policy Information Authorization

Traditional and Variable Life Series

Policy information may be released directly to a third party, authorized by the Policyowner(s) to receive contract information. This authorization must be completed, currently dated and signed by the Policyowners(s). Provided that this form is completed in its entirety, it will be valid for three years from the date of the signature unless limited in duration upon written notification or, if undated, the date received at our administrative office.

We reserve the right to deny the release of policy information to a third-party contact authorized by the Policyowner(s). Former Associates of AXA Advisors cannot be designated as third party recipients of life insurance information. This authorization is void after any change in ownership.

I (We) hereby authorize AXA Equitable Life Insurance Company/AXA Life and Annuity Company/MONY Life Insurance Company of America to release the information specific to the policies listed below to my designated third-party contact for a period of three years.

Changes to the policy are not permitted under the authority of this authorization. All requests to make policy changes must be submitted by the Policyowner(s) to our administrative office. The Policyowner(s) can at any time during this period terminate the third-party authorization by writing to our administrative office.

Return:

Express Mail:
AXA Equitable Life Insurance Company
National Operations Center
10840 Ballantyne Commons Parkway
Charlotte, NC 28277

Regular Mail:
AXA Equitable Life Insurance Company
National Operations Center
P.O. Box 1047
Charlotte, NC 28201-1047

Toll-free Fax Number:
(855) 268-6378

For Assistance:

Call:
(800) 777-6510
Monday–Friday
8:00 a.m. – 7:00 p.m. ET

To Sign Up For eDelivery:

Visit us at
www.axa-equitable.com

1. Type of Request

Please complete the sections listed below if you are requesting a:

- Third-Party Release of Information — sections 2, 3, 4 and 5

2. Owner's Information (Please Print)

Policy Number(s) (Required):

☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐

Insured's Name: _____
Last, First, Middle Initial

Owner's Name (if other than insured): _____
Last, First, Middle Initial

Owner's Daytime Telephone Number: ☐☐☐-☐☐☐-☐☐☐☐

Owner's Email Address: _____

Joint Owner's Name: _____
Last, First, Middle Initial (if applicable)

Owner's Address: _____
Number and Street — Apt. / Suite / Floor

_____
City — State — Zip

For Addresses Outside the United States:

Country: N/A Country Postal code: N/A

☐ Please check if this is an address change.

E14708 Cat. #134876 (9/12)

American Fidelity Assurance Company
A member of the American Fidelity Group

Life Division
PO Box 268923
Oklahoma City, OK 73126-8923
Phone (800) 735-9701
Fax (405) 523-3841
www.AFAdvantage.com

Authorization to Release Information

Policy Number

Policyowner's Address

Insured

City, State, Zip

Policyowner (if different from Insured)

Telephone Number

I/We, _____, authorize Danielle Burns, Luke Ramsey to obtain policy information on my behalf, until revoked in writing by the policyowner.

Mailing Address: The ASA Group
11807 Hinson Rd.
Little Rock, AR 72212

Phone Number: 501-224-7739

Signed at _____ (City) _____ (State) on _____ (Date) 20 _____

_____
Signature of Policyowner

3. Type of Information to be released

Please select the information you are authorizing to be released to the third-party upon their request:

- ☑ Policy values (Face Amount, Death Benefit, Cash Values, Loan Values)
- ☑ Inforce Illustration *(A projection of the policy's future values and earnings [if applicable]. You may request illustrations created without any changes, or you may request an illustration that shows features being removed or added as well as changes in the premium amounts.)* We reserve the right to charge an administrative fee per illustration requested.
- ☑ Loan information.
- ☑ Premium information.
- ☑ Other: See attached request sheet/ Beneficiary information, cost basis, annual statement, premium history
  (The Policyowner(s) must be specific as to the information the third-party is to receive)

  Please note: this authorization is not valid for the release of any medical information.

4. Information about the Third-Party

To release information to a third-party, the following information is required:

Name of Authorized Party(ies): Danielle Burns, Luke Ramsey
(Please print)

Note: Former Associates of AXA Advisors cannot be designated as third-party recipients of life insurance information.

Relationship to Policyowner(s): Insurance Review Specialist
(Please print)

Entity name (if applicable) The ASA Group
(Please print)

Address of Authorized Party(ies): 11807 Hinson Rd, Little Rock AR 72212
(Required for telephone verification purposes)

Daytime Phone Number of Authorized Party(ies): (501) 224-7739
Please select how this information is to be released to the third party contact:

- ☑ Verbally – The third-party must contact the National Operations Center to obtain the selected information. The information provided above will be verified at the time of the call.
- ☑ Fax to : (501) 400-8578. The Policyowners(s) should specify the fax number of the third-party.
- ☑ Written correspondence (mailed to the third-party's address indicated above)
- ☑ Email to PHS@theasagroup.com. The Policyowner(s) should specify the email address of the third-party.
- ☑ By checking this box, I authorize the third-party shown above to provide AXA Equitable with a fax number, email address or physical address at the time information is requested.

Note: We reserve the right to release requested information directly to the Policyowner(s) if we consider a previously established authorized third-party presents risks to upholding AXA Equitable's Privacy Policy or otherwise jeopardizes the policy remaining in effect.

5. Signatures

Signature: N/A
Signature of Owner

Current Date (mm/dd/yyyy)

Signature: N/A
Signature(s) of Joint Owner(s)

Current Date (mm/dd/yyyy)

Signature:
Signature of Corporation Officer, Partner or Trustee

Title (Required)

Current Date (mm/dd/yyyy)

Print Name of Corporation, Partnership or Trust (Required)

General Information about Signature Requirements

Multiple/Joint Owners: Must be signed by all Owners.

Corporation: One officer other than the Insured on behalf of the corporation.

Attorney-in-Fact/Guardian: Must be signed by either the Attorney-in-Fact or Guardian with their title listed. A copy of the appointment is needed if it is not already on file.

Individual/Pension Trust: Must be signed by Trustee(s).

Partnerships: Requests must be submitted in the name of the Partnership and signed by a partner other than the Insured, or two partners if Insured signs.

Other: For cases such as minor owners, contact the National Operations Center for appropriate signature requirements.

Cat. #134876 (9/12)

Authorization to Release Information

ATHENE
www.athene.com

Mail or fax completed form to:
P.O. Box 1555, Des Moines, IA 50306-1555 Fax: 800 531 0038

Contact us:
Annuity Customer Contact Center - Tel: 888 266 8489
Life Customer Contact Center - Tel: 800 800 9882

Athene Annuity and Life Company
7700 Mills Civic Parkway, West Des Moines, IA 50266-3862
Athene Life Insurance Company of New York

INSTRUCTIONS

- Use this form to designate 1 or 2 authorized individuals to obtain information about your policy/contract(s).
- This authorization allows for the release of information ONLY. It does NOT allow the authorized person to make changes to the policy/contract(s) listed on this release form.
- You can also call one of our Customer Contact Centers listed above to make this request.
- Attached documentation must be signed and dated by the owner.
- This authorization is valid until revoked by the owner. The owner reserves the right to revoke this authorization at any time for any reason by calling us at the number listed above or by submitting a written request.
- When contacting our offices the authorized party will need to verify the last four digits of the OWNER'S Social Security Number, the OWNER'S date of birth and the OWNER'S password (if applicable) when requesting information.

1. INFORMATION ABOUT THE OWNER

Individual, Trustee or Company Name		Contract/Policy Number(s)			
If Trust, list Trust Name and Trust Date					
Mailing Address		City	State	Zip	Country
Street Address (**REQUIRED** if mailing address is a PO Box)		City	State	Zip	Country
Social Security Number (last four digits) XXX-XX-	Date of Birth (mm/dd/yy) / /		Email Address		
Personal Phone ( ) -	Business Phone ( ) -	☐ Address Change Requested (Confirmation of this change will be sent to you prior to processing this request.)			

2. AUTHORIZED PARTY #1

Full Name* Danielle Burns				
Mailing Address* 11807 Hinson Road	City* Little Rock	State* AR	Zip* 72212	Country USA
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country
Personal Phone ( ) -	Business Phone (501) 224 - 7739	Email Address DBURNS@THEASAGROUP.COM		

* Required Information

☐ Check if have attached additional sheets for more than two authorized parties.

17624031401

Authorization to Release Information

ATHENE
www.athene.com

3. AUTHORIZED PARTY #2

Full Name* Luke Ramsey				
Mailing Address* 11807 Hinson Road	City* Little Rock	State* AR	Zip* 72212	Country USA
Street Address (**REQUIRED** if mailing address is a PO Box)	City	State	Zip	Country
Personal Phone ( ) -	Business Phone (501) 224 - 7739	Email Address LRAMSEY@THEASAGROUP.COM		

* Required Information

4. LIMITATIONS

Please list below any information you would **not** like to be released to the listed authorized party(ies):

5. YOUR CONFIRMATION

I authorize the named person/people to receive information on the referenced policy/contract(s):

Owner Signature X	Owner's Title (if corporation or trust)	Date (mm/dd/yy) / /
Joint Owner Signature X	Print Name	Date (mm/dd/yy) / /

If you are signing on behalf of the owner, check one of the boxes to indicate the capacity in which you are signing and provide documentation to verify your authorization to act on behalf of the owner.

☐ Conservator ☐ Guardian ☐ Power of Attorney ☐ Assignee

Signature X	Print Name	Date (mm/dd/yy) / /

We appreciate your business and are committed to providing you with accurate and caring service. If you have any questions or need additional information, contact your Insurance Professional or our Contact Center.

AUTHORIZATION FOR CONTINENTAL CASUALTY COMPANY (CNA INSURANCE COMPANIES) TO DISCLOSE INFORMATION

I, _____ hereby authorize the use or disclosure of personal health information about me as described below.

- ■ Release any and all information concerning my insurance claim, entitlement to benefits, medical history, transaction history with the insurance company, or other information related to insurance or care being paid for by my insurance coverage.
- ❑ Release only the following information _____

The release authorized above is for the following purpose (if none is stated then it is at my request).
Purpose: Life Insurance Review

The Group Long Term Care Plan from CNA may release my personal health information, which is described above to the following person(s) or group of persons:

NAME	ADDRESS
Luke Ramsey	11807 Hinson Road, Little Rock, AR 72212
Danielle Burns	11807 Hinson Road, Little Rock, AR 72212

If you are the representative of an insured, describe the scope of your authority to act on their behalf:

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

As described in the Notice of Privacy Practices of Group Long Term Care Plan from CNA I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Group Long Term Care Plan from CNA in reliance on this authorization, by sending a written revocation to: P.O. Box 946760, Maitland FL 32794-6760.

- ❑ This authorization will expire two years after the signature date
- ❑ This authorization will expire ____/____/____
- ⊡ This authorization is effective until revoked in writing

I understand that I am not required to sign this authorization form and the Group Long Term Care Plan from CNA will not condition the provision of payment to me on the signing of this authorization. I understand that this authorization does not, in itself, authorize anyone to act on my behalf or satisfy any requirements for information requested by CNA. I further understand the Group Long Term Care Plan from CNA cannot release information to any unauthorized third party without my signature.

I agree that I have a copy of this Authorization. I understand that I may request, at any time, to receive a copy of this Authorization and agree that a photostat copy of this Authorization shall be as valid as the original.

Signature of Insured or Legal Representative

_____

Date: _____

Print name of Insured/Legal representative (if applicable)

_____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, am the owner of a policy administered by Conseco.

By fully completing and signing this form, I authorize the Company to disclose information to the following person or entity: Luke Ramsey, Danielle Burns

This authorization covers all information pertaining to policy number _____, unless exclusions are listed below.

Exclusions: _____

This authorization shall take effect immediately and shall remain in effect for a period of one (1) year from the date of my signature. A copy ofthis authorization may be used in place of the original.

I understand that I have the right to revoke my authorization at any time, except to the extent that it has been relied on already. Revocation requests must be sent in writing to:

Conseco Services, LLC
P.O. Box 1963
Carmel, IN 46082-1963

_____ _____
Signature of Policy Owner Date

_____ _____
Insured's Date of Birth Owner's Social Security Number

Date_____

Fidelity Life Association
1121 West 22nd St.
Suite 209
Oak Brooke, IL 60523

Re: policy #_____Insuring the life of _____

To whom it may concern,
Please allow this signed and notarized letter to serve as authorization for Fidelity Life Association to disclose any and all information on the above policy for a 3 years period to The ASA Group, Luke Ramsey or Danielle Burns. This authorization shall be valid for 3 years beginning on the date of this letter.

Best regards

Owner Signature

Owner Printed name

Notary public Signature Date Notary Public Stamp

Jackson National Life Insurance Company

877-627-3618

I am requesting an Illustration/Reprojection for policy number _____, insuring the life of

_____

Name and Phone of contact in the event we have questions

_____

Universal Life Policy

_____ Current death benefit and premiums
_____ Minimum premiums to endow at maturity
_____ Minimum premiums to carry to maturity
_____ Other specific request

_____
_____
_____

We provide one illustration request, with up to three re-proposal scenarios per policy per year at no charge. Any additional requests require $25.00 fee prior to running the illustration.

I have enclosed a check or money order payable to Jackson National Life Insurance Company for:

_____	First request per year	Free
_____	Additional requests	$25.00 each
	TOTAL	$ _____

Please allow 7-14 business days from the date of receipt in our office for processing.
Thank you.

Please return illustration to:

Name: Luke Ramsey, Danielle Burns
Address: 11807 Hinson Rd.
Little Rock, AR 72212
Fax: 501-400-8578
Phone: 501-224-7739

_____ _____

Policy Owner Signature Date

Lincoln Financial Group®

The Lincoln National Life Insurance Company
Lincoln Life & Annuity Company of New York
PO Box 21008, Greensboro, NC 27420-1008
(hereinafter referred to as "the Company")

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Policy Number: _____ Insured's Name: _____

Insured's Date of Birth: _____ Policyowner's Social Security Number: _____

1. I (the undersigned) authorize the Company to disclose to my Representative information from the Company's files related to the Policy identified above:

   Name of Representative: Luke Ramsey Relationship: Insurance Review Specialist

   Address: 11807 Hinson Rd, Little Rock, AR 72212

2. I understand that the information disclosed by the Company may include:
   - Personal information: including, but not limited to, names, addresses, Social Security numbers, financial and employment history. The Company will not release health history or medical records.
   - Information about transactions with the Company: such as products purchased, account balances, payment history, policy changes, beneficiary designations, loan history.
   - Information collected from consumer reporting agencies: such as credit history, credit scores, driving or employment records.
   - On-line information: from on-line forms, site visitorship data and other information that the Company may have obtained through its web sites.

   In the space provided below, I direct the Company to limit the information that may be disclosed to my Representative, as follows:

   _____

   _____

3. I understand that any information disclosed to my Representative may no longer be protected by federal or state law and may be used by the Representative for purposes unrelated to my Company account(s). I hereby release, on behalf of myself, my heirs, my assigns, administrators and executors, the Company, its employees, officers, directors, shareholders, successors and assigns, from any and all losses, damages, liability, expenses or any other monetary expenditures incurred by reason or upon account of a disclosure pursuant to this Authorization.

4. I understand that I may revoke this Authorization at any time, except to the extent the Company has already taken action in reliance on it. Unless I revoke this Authorization sooner, it shall remain valid for:

   6 months 1 year ■ Indefinitely Other _____

   Unless I have designated a specific duration above, I understand that the Company will disclose only the information currently requested and that a new Authorization will be required for any future request.

5. A photocopy of this Authorization shall be considered as valid as the original.

_____ _____
Signature of Policyowner Date

_____ _____
Signature of Joint Owner Date

MassMutual FINANCIAL GROUP℠

Third Party Authorization Form

For use with Life, Disability, Annuity and Individually Owned Executive Benefit products

Massachusetts Mutual Life Insurance Company
and affiliates, Springfield, MA 01111-0001

www.massmutual.com

1 **This authorization applies to the following policy(s)/contract(s) –** *attach list if this authorization applies to more than four contracts/policies. All contracts/policies listed must have the same owner.*

Contract/Policy Number(s):	**Name of Annuitant/Insured(s):**

Product Type: ☐ Annuity ☐ Disability ☐ Executive Benefit ☐ Life ☐ Multiple Products

2 **Terms and Conditions**

- This Authorization form, completed and signed properly by the owner, authorizes MassMutual to provide the following party/parties with *general contract/policy information* on the above referenced contract(s)/policy(s) over the phone or in writing for the duration identified on this form.
- Examples of general contract/policy information include but are not limited to value quote, ownership/beneficiary designation, contract/policy status, insurance coverage amount and premium/payment information.
- This form *does not* allow the authorized party/parties to exercise any contract/policy owner rights or to initiate any contract/policy changes.
- MassMutual *will not* provide the authorized party/parties with information that might violate contract/policy owner privacy rights, such as social security numbers or medical information.
- This authorization will become null and void upon a change in ownership or the death of the policy owner or insured.
- The owner of the contract/policy may cancel this authorization at any time by calling the Service Center or submitting a written request to MassMutual, Document Management Services, 1295 State Street, Springfield MA 01111.

3 **Authorized Party(ies)** Information will be released to the individual(s) listed below.

Authorized Individual(s) *(example: spouse, child, etc.)*

Name of Primary Individual: Danielle Burns Date of Birth: Last Four of SSN:

Complete Address: 11807 Hinson Rd., Little Rock, AR 72212 Relationship to Owner: LIR Specialist

Email Address: dburns@theasagroup.com Fax: 501.320.2674

Name of Secondary Individual: Luke Ramsey Date of Birth: Last Four of SSN:

Complete Address: 11807 Hinson Rd., Little Rock, AR 72212 Relationship to Owner: LIR Specialist

Email Address: lramsey@theasagroup.com Fax : 501.320.2674

Authorized Organization (Corporation or Trust)

(Please attach corporate resolution listing names and titles of individual(s) authorized to receive information)

Complete Name of Organization: _____

Name and title of Primary Authorized Individual: _____

Name and title of Secondary Authorized Individual: _____

Complete Address of Organization: _____
Address City State ZIP

Daytime Phone Number: _____

Fax Number: _____ Email Address: _____

Last four of Tax Identification Number: _____

4 Duration of Authorization

Place an X in the appropriate box to designate the duration of this authorization. **If no duration is selected, the default duration for this authorization will be one year.** This authorization will be in effect from the date this form is signed.

☐ one year ☑ two years

5 Signature Section

By signing below, the owner(s) acknowledge(s) that they have read and agree to the Terms and Conditions on page 1 of this form. I will indemnify and hold Massachusetts Mutual Life Insurance Company, its affiliates and its directors, officers and employees harmless from any and all liabilities and costs, which may be incurred by relying upon this authorization. Refer to page 3 of this form for specific instructions regarding signature requirements.

Individual, Joint or Multiple Owners Signature Section (All owners must sign)

Printed Full Name of Owner	Signature of Owner	Date Signed
Printed Full Name of Additional Owner (if applicable)	Signature of Additional Owner	Date Signed
Printed Full Name of Additional Owner	Signature of Additional Owner	Date Signed

Contract/Policy Owner Email Address

Contract/Policy Owner Daytime Phone Number

Corporate, Partnership or Trust Owned Signature Section

Printed Full Name of Corporation, Partnership or Trust		Date of Trust	Date Signed
Printed Full Name of Corporate Officer or Trustee	Title	Signature of Corporate Officer or Trustee	Date Signed
Printed Full Name of Corporate Officer or Trustee	Title	Signature of Corporate Officer or Trustee	Date Signed

6 Customer Service Information

Please mail or fax your completed request to:

Mailing Address
Document Management Services
1295 State Street
Springfield MA 01111

Fax Number

1-866-329-4527

For additional information regarding your policy, please use the following resources:

Internet Service Connection
www.massmutual.com

MassMutual Customer Service Center
1-800-272-2216
Monday through Friday, 8 a.m. – 8 p.m. Eastern Time

Signature Instructions

The following descriptions explain the signature requirements for each type of ownership arrangement.

Corporation, partnership, limited partnership

Include the full name of the corporation. Print or type the full name and corporate title of each officer who signs. If the officer is the insured or a family member, we require the signature of another officer who is not related or, if all officers are related, the signature of two officers. If the insured is the only officer, we require either a letter on company stationary to that effect or the insured's signature with the corporate seal affixed. ***EXAMPLE*** - John Doe, President/Partner/General Partner, ABC Corporation

Trust **

Those trustees required to sign under the trust agreement. Include the full name of the trust, the date of the trust agreement and the title(s) of the officer(s), if corporate trust, signing. ***EXAMPLE*** – Mary Smith as Trustee under the ABC Trust Agreement dated mm/dd/yyyy

Custodian

- In all states except South Carolina and Vermont, include the full name of the custodian "as custodian for (*insert name of minor*) under the (*name of state*)'s UTMA." **EXAMPLE** –Joan Doe as custodian for Alice Doe under the Massachusetts UTMA.
- In South Carolina and Vermont, include the name of the custodian "as custodian for (*insert name of minor*) under the (*name of state*)'s UGMA." **EXAMPLE** –Joan Doe as custodian for Alice Doe under the Vermont UGMA.

Executor**

Include the full name of the appointed executor, administrator, or personal representative, as "executor, administrator, or personal representative (*list only one capacity*) for the estate of (*insert name of deceased*), deceased." If not previously submitted, a copy of the death certificate is required. **EXAMPLE** – Joan Doe, executor for the estate of Sam Doe, deceased.

Legal Guardian /Conservator**

Include the full name of the legal guardian/conservator, "as guardian/conservator of the estate of (*insert name of person affected*)." **EXAMPLE** – Joan Doe as Guardian/Conservator of the Estate of Sam Doe.

Attorney-in-Fact (Power of Attorney)**

Include the full name of the attorney-in-fact as "Attorney-in-Fact for (*insert name of person*)."**EXAMPLE** – Joan Doe, Attorney-in-Fact for Sam Doe.

**** Copies of the legal document that established authority must be submitted with this form unless already on file.**

The Ohio National Life Insurance Company
Ohio National Life Assurance Corporation

Post Office Box 237
Cincinnati, Ohio 45201-0237
Telephone: 800.366.6654

Ohio National Financial Services

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I, _____, born on _____, am the designated Owner of the following life insurance policy(ies) and/or disability income insurance policy(ies), which are issued or administered by either The Ohio National Life Insurance Company or Ohio National Life Assurance Corporation, collectively or individually as applicable ("Ohio National"):

_____, _____, _____

_____, _____, _____

I hereby authorize Ohio National to release to Danielle Burns, Luke Ramsey (Name), my LIR Specialist (Relationship to Owner),

the selected types of information about the above-referenced life insurance policy(ies) and/or disability income insurance policy(ies):

- ☐ Copies of annual or other periodic statements or confirmation statements
- ☐ Current in-force illustration
- ☐ Current cash surrender value and value of individual portfolios
- ☐ Current death benefit and death benefit type
- ☐ Identity of owners and beneficiary(ies)
- ☐ Dividend election and amount
- ☐ Premium allocation to variable portfolios or Fixed Account
- ☐ Existence of collateral assignments
- ☐ All of the above
- ☐ Other: _____.

This authorization is effective, as needed, for 24 months from the date signed or as permitted by law, whichever is less. A photocopy or facsimile of this authorization may be used the same as the original. I have read this Authorization and received a copy of it. I understand that I may revoke this Authorization by sending written notice to Ohio National. Revocation shall become effective as of the date Ohio National receives the notice, subject to any action taken by Ohio National prior to Ohio National receiving upon the notice of revocation.

_____ _____
Signature of Owner Date

If signed on behalf of Owner, the signer has the following relation to the Owner:

- ☐ Parent/Guardian of Minor
- ☐ Guardian or Conservator of Person Judicially Declared to be Incompetent
- ☐ Attorney-in-Fact under Power of Attorney
- ☐ Executor/Executrix or Administrator of deceased's estate
- ☐ Other: _____

An authentic copy of the document establishing such relationship must be provided to Ohio National.

TITLE

PACIFIC LIFE INSURANCE COMPANY
Life Insurance Division
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 398-0467
www.PacificLife.com

PACIFIC LIFE

OTHER INTERESTED PARTY AUTHORIZATION REQUEST (OIP)

Completing this form will revoke any previous authorization to release information on file with Pacific Life Insurance Company (PLIC) to other interested parties.

Insured's Name: First	MI	Last	Policy Number(s):
Policyowner's Name:			Telephone #: (include area code)

1 CONSENT TO RELEASE INFORMATION (Address information required)

I authorize PLIC to release by telephone or written request policy information to the party(ies) listed until revoked in writing.

Note: Private information such as a SSN/TIN, underwriting, and medical information are automatically excluded from this authorization.

This authorization shall remain in effect for the time period selected below, or if no option is selected it will remain in effect indefinitely, unless revoked in writing.

☑ Indefinitely ☐ 1 Year (Effective from the date signed, or if not dated, from the date received at our office.)

Other Interested Party's (OIP) Name				Relationship to Policyowner
Danielle Burns, Luke Ramsey				Other
Address: Street	**City**	**State**	**Zip Code**	**Telephone #: (include area code)**
11807 Hinson Road	Little Rock	AR	72212	(501) 224-7739

If OIP is a corporation or business entity, indicate Authorized Party's names below:

Authorized Party's Name: First	MI	Last	Title:
Additional Authorized Party's Name: First	MI	Last	Title:
Additional Authorized Party's Name: First	MI	Last	Title:

2 CONSENT FOR DUPLICATE MAILINGS (If applicable)

I authorize PLIC to send the following regularly scheduled mailings to the OIP until revoked in writing.
(Note: Duplicate mailings may not be available on some policies.)

☐ Statements & Confirmation Notices ☐ Billing, Grace, and Lapse Notices ☐ Grace and Lapse Notices ☐ All

3 REQUEST TO STOP DUPLICATE MAILINGS (If applicable)

I request that PLIC discontinue the following regularly scheduled mailings to the OIP.

☐ Statements & Confirmation Notices ☐ Billing, Grace, and Lapse Notices ☐ Grace and Lapse Notices ☐ All

4 REQUEST TO REMOVE THE OIP (If applicable)

I request that PLIC remove _____ as an OIP from the policy.

PL%TITLE%PL2

PACIFIC LIFE INSURANCE COMPANY
Life Insurance Division
P.O. Box 2030 • Omaha, NE 68103-2030
(800) 347-7787 • Fax (866) 398-0467
www.PacificLife.com

PACIFIC LIFE

Insured's Name: First	MI	Last	Policy Number(s)

5 DECLARATIONS

I understand and agree:

- That PLIC will use reasonable procedures to confirm that requests are authorized and genuine. As long as these procedures are followed, PLIC and its affiliates and their directors, trustees, officers, employees, representatives and/or agents will be held harmless for any claim, liability, loss or cost.
- That PLIC is not responsible for inquiring into the reason for the request for information or the subsequent use of the information provided.
- That requests are subject to the policy's terms and conditions and PLIC's administrative requirements.
- This authorization is void upon any change in ownership.
- That PLIC reserves the right to decline this request at its sole discretion.

6 SIGNATURES

If you are signing on behalf of an entity, you represent that you are authorized to execute this document and to make the statements that may be shown. You further represent that all requirements of those entities, including the use of any seal (in the case of a Corporation) and any authorized signatures (in the case of a Corporation and/or Trust), have been met.

SIGNED AND DATED ON:

Date (mm/dd/yyyy)

SIGN HERE
X
Policyowner's* Signature

Policyowner's Name: First	MI	Last (print)	Title, if applicable

SIGN HERE
X
Assignee's* Signature (if applicable)

Assignee's Name: First	MI	Last (print)	Title, if applicable

SIGN HERE
X
Other Required* Signature (Must check a box below)

Other Required Name: First	MI	Last (print)	Title, if applicable

Indicate role of "Other Required" Signature:

☐ Additional Policyowner ☐ Attorney-in-Fact
☐ Additional Assignee ☐ Business Entity's Authorized Representative
☐ Trustee ☐ Other:_____

*If a Corporation, Trust or Business Entity, the full name of the Corporation, Trust or Business Entity must be shown below.

Corporation, Trust, or Business Entity's Name

PRODUCER: PROVIDE A PHOTOCOPY OF THIS SIGNED FORM TO ALL SIGNING PARTIES

15-30276-02 07/2012

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Survivorship Universal Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. 1st Insured DOB
5. 2nd Insured DOB
6. Face amount of policy
7. Scheduled premium
8. Premium mode
9. Paid to date/next due date
10. Cost basis/total premiums paid
11. Account value
12. Cash surrender value
13. Loan amount
14. 1st Insured issue class
15. 2nd Insured issue class
16. Policy maturity date
17. Maturity options-What happens at maturity
18. Riders (including guarantee riders)
19. Copy of last annual statement
20. An inforce illustration showing no premium continued.
21. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid.
22. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 (of the younger insured)

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Survivorship Whole Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. 1st Insured DOB
5. 2nd Insured DOB Base
6. Face amount Dividend
7. Face amount
8. Total Face amount
9. Scheduled premium
10. Premium mode
11. Paid to date/next due date
12. Cost basis/total premiums paid
13. Base Cash value
14. Dividend Cash Value
15. Total Cash surrender value
16. Loan amount
17. 1st Insured issue class
18. 2nd Insured issue class
19. Policy maturity date
20. Maturity options-What happens at maturity
21. Riders (including guarantee riders)
22. Copy of last annual statement
23. An inforce illustration showing no premium continued.
24. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid.
25. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 (of the younger insured)

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Survivorship Whole Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. 1st Insured DOB
5. 2nd Insured DOB
6. Base Face amount
7. Dividend Face amount
8. Total Face amount
9. Scheduled premium
10. Premium mode
11. Paid to date/next due date
12. Cost basis/total premiums paid
13. Base Cash value
14. Dividend Cash Value
15. Total Cash surrender value
16. Loan amount
17. 1st Insured issue class
18. 2nd Insured issue class
19. Policy maturity date
20. Maturity options-What happens at maturity
21. Riders (including guarantee riders)
22. Copy of last annual statement
23. An inforce illustration showing no premium continued.
24. An inforce illustration showing a level ongoing premium of $_____/Annual being paid.
25. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 (of the younger insured)

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Universal Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. Insured DOB
5. Face amount of policy
6. Scheduled premium
7. Premium mode
8. Paid to date/next due date
9. Cost basis/total premiums paid
10. Account value
11. Cash surrender value
12. Loan amount
13. Issue class
14. Policy maturity date
15. Maturity options-What happens at maturity
16. Riders (including guarantee riders)
17. Copy of last annual statement
18. An inforce illustration showing no premium continued.
19. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid.
20. An inforce illustration solving for the premium necessary to carry the death benefit through age 100

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Variable Universal Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. Insured DOB
5. Face amount of policy
6. Scheduled premium
7. Premium mode
8. Paid to date/next due date
9. Cost basis/total premiums paid
10. Account value
11. Cash surrender value
12. Loan amount
13. Issue class
14. Policy maturity date
15. Maturity options-What happens at maturity
16. Riders (including guarantee riders)
17. Copy of last annual statement
18. An inforce illustration showing no premium continued and assuming a 6% ROR
19. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid and assuming a 6% ROR.
20. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 ($1 at age 100) assuming 6% ROR

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Indexed Universal Life Policy information request policy # _____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. Insured DOB
5. Face amount of policy
6. Scheduled premium
7. Premium mode
8. Paid to date/next due date
9. Cost basis/total premiums paid
10. Account value
11. Cash surrender value
12. Loan amount
13. Issue class
14. Policy maturity date
15. Maturity options-What happens at maturity
16. Riders (including guarantee riders)
17. Copy of last annual statement
18. An inforce illustration showing no premium continued and assuming a 6% ROR
19. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid and assuming a 6% ROR.
20. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 ($1 at age 100) assuming 6% ROR

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

Owner's Signature

Owner's Printed Name

Date:_____

Penn Mutual Life
Policy Owner Service Department
Philadelphia, PA 19172

RE: Whole Life Policy information request policy #_____

To Whom It May Concern:
Please accept this letter to release policy information to me as soon as possible. I have listed the specific information I would like on the above policy.

1. Policy date
2. Owner name
3. Beneficiary name
4. Insured DOB
5. Base Face amount
6. Dividend Face amount
7. Total Face amount
8. Scheduled premium
9. Premium mode
10. Paid to date/next due date
11. Cost basis/total premiums paid
12. Base Cash value
13. Dividend Cash Value
14. Total Cash surrender value
15. Loan amount
16. 1st Insured issue class
17. Policy maturity date
18. Maturity options-What happens at maturity
19. Riders (including guarantee riders)
20. Copy of last annual statement
21. An inforce illustration showing no premium continued.
22. An inforce illustration showing a level ongoing premium of $ _____/Annual being paid.
23. An inforce illustration solving for the premium necessary to carry the death benefit through age 100 ($1 of value at age 100 assuming current dividend scale)

Please fax the above information to 501-320-2674. If you will not fax please forward information to address of record for the policy.

Your help is appreciated and anything you can do to expedite this process will be greatly appreciated.

Best regards,

PHOENIX® Phoenix Life Insurance Company
PHL Variable Insurance Company

Disclosure Authorization for Release of Policy/Contract Information

Quick Reference

Attached is the form you requested. In order for your request to be processed in a timely manner, the **sections referenced below must be completed on the accompanying form.**

Section A - Required Fields

- Policy/Contract Number(s)
- Insured/Annuitant Name(s)
- Name of Authorized Party - For Non-Individuals, attach a list of Authorized Individuals
- Identification Code - will confirm identity of the Authorized Party
- Nature of Information
- Purpose of Collecting Information
- Signature(s) of Owner(s)
- Signing Date

Section B - Required Fields

Signature requirements are based on the owner designation of the policy/contract. Examples are:

- **Individual Owner**: Print and sign your full name as it appears on the policy/contract.
- **Multiple Owners**: All owners must sign.
- **Partnership**: All partners must sign (unless a form authorizing one partner to sign is on file with us).
- **Corporation**: Titled officer must sign. The officer's title must also be indicated.

  NOTE: In general, the insured/annuitant should not sign as officer. We ask that an additional titled officer sign if the signing officer is effecting a change for his or her personal benefit.
- **Trust**: The current trustee(s) must sign.

*All **forms must be dated** in order to process your request.*

Contact Information

Delivery

- *U. S. Mail:*
  PO Box 8027
  Boston MA 02266-8027
- *Shipping:*
  30 Dan Road, Suite 8027
  Canton MA 02021-2809

Phone

- (800) 628-1936 (Traditional Life)
- (800) 541-0171 (Variable Life or Annuity)

FAX

- (816) 502-4920 (Traditional Life)
- (816) 221-7036 (Variable Life)
- (816) 221-9674 (Annuity)

PHOENIX®

Phoenix Life Insurance Company
PHL Variable Insurance Company
Phoenix Life and Annuity Company
PO Box 8027, Boston MA 02266-8027

Disclosure Authorization for Release of Policy/Contract Information

Section A - Release Information

Regarding the following policy/contract number(s), I authorize Phoenix to release the non-medical information specified below to the individual or company named for the purpose described. This is not an authorization to conduct policy/contract transactions on my behalf.

Policy / Contract Number(s)	Insured / Annuitant Name(s)

Policy / Contract Number(s)	Insured / Annuitant Name(s)

Information may be provided by the Phoenix Customer Care Center to the following individual or company:

Name of Authorized Individual/Company (If entity owned, attach list of authorized individuals, with contact telephone number)	REQUIRED - Identification Code (A code created by the authorized party to confirm their identity)
Danielle Burns, Luke Ramsey	1985

☑ Check here if the above named is an Advisor, Insurance Institution or Insurance Service Organization.

The nature of the information to be disclosed is as follows: (If nothing checked, the section will default to Account Values.)

☐ **ALL** Non-medical Information
OR one or more of the following specific types of non-medical information
☐ Title/Registration - owner/beneficiary designation, collateral assignment
☐ Billing - premium amount/frequency, type of billing
☐ Account Values - cash value, taxable gain, death benefit
☐ Illustrations - projected values based on hypothetical scenarios

The purpose of collecting the information is as follows: (Must be completed for request to be valid.)

Complete Life Insurance Review

Section B - Signature(s)

This authorization is valid for three (3) years from the date signed.
This authorization may be revoked at any time upon written request from the owner.
This form revokes any prior authority given to this authorized party.

Owner

If the OWNER is an INDIVIDUAL, complete the following.

Owner (Print First, Middle, Last)	Signature	Witness Signature	State Signed In	Date (mm/dd/yyyy)
N/A	N/A	N/A	N/A	N/A
Joint Owner (Print First, Middle, Last)	**Signature**	**Witness Signature**	**State Signed In**	**Date (mm/dd/yyyy)**
N/A	N/A	N/A	N/A	N/A

Non-Individual Owner

If the OWNER is a NON-INDIVIDUAL, complete the following.

Full Name of Trust, Entity, Corporation or Other: _____

Signing in the capacity as:

☐ Trustee ☐ Partner ☐ Officer _____ (List corporate title) ☐ Other _____

Name (Print First, Middle, Last)	Signature	Witness Signature	State Signed In	Date (mm/dd/yyyy)
Name (Print First, Middle, Last)	Signature	Witness Signature	State Signed In	Date (mm/dd/yyyy)
Name (Print First, Middle, Last)	Signature	Witness Signature	State Signed In	Date (mm/dd/yyyy)

Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group®
P.O. Box 10431, Des Moines, IA 50306-0431
www.principal.com
Your policy indicates its issuer, which is the company responsible for the policy obligations and is referred to herein as the 'Company'.

Authorization For Release of Information

Call: 800-247-9988
Fax: 866-885-0390

Policy Number(s)	Policyowner Name	Phone Number
		( )

Requests for illustrations: Your policy requires the Company to provide one current inforce illustration each year to Policyowner(s) without charge. Under this Authorization, the Authorized Party may make 4 requests for illustrations per calendar year per policy. We reserve the right to change this service level and/or charge for services at any time.

I, the policyowner, authorize the Company to release information about this policy(ies) to the person(s) listed below.

a) I understand that the person(s) named on this form will replace any previously named authorized person(s).

b) I understand this form authorizes only the release of policy information (not personal medical information) on my insurance policy(ies), and does not authorize the person/entity designated below to exercise policy rights and provisions.

c) I understand and agree that the Company may terminate this authorization at its discretion at any time without prior notice.

d) This authorization will remain in effect until the Company receives either 1) notice from me that such authority has been revoked, 2) acceptable proof of an owner's death, or 3) a change in ownership of the policy. The Company must receive notice of these events in a form acceptable to the Company.

e) I agree to indemnify and hold the Company and its directors, officers and employees harmless from all liabilities and costs, including attorney fees, which it may incur by relying on this authorization.

f) I understand that the authorized person(s) will be authenticated at each request. This authentication involves the authorized person providing certain policy or owner specific information.

Information about the Authorized Party

If your authorized party is a Company or Trust, please list no more than 5 authorized representatives below.

Name of Authorized Person(s)

Danielle Burns, Luke Ramsey

Company Name, if applicable

Agency Services of Arkansas, Inc. dba The ASA Group

Address (Street, City, State, and Zip Code)	Contact Phone Number
11807 Hinson Rd., Little Rock, AR 72212	(501) 224-7739

Signatures (All Policyowners must sign and date. If this form is not dated, it will be effective the date we receive it.)

1. Policyowner Signature (include Title if Corporate owned or Trustee if Trust owned)	Date
2. Policyowner Signature (include Title if Corporate owned or Trustee if Trust owned)	**Date**

If signing on behalf of another, * provide relationship

* If this authorization is signed by someone other than the policyowner, please include the proper documentation that attests to your ability to sign (certified letters of appointment of the representative of an estate, power of attorney, etc.).

Provident Life and Accident Insurance Company

800-874-7496

I am requesting an Illustration/Reprojection for policy number insuring the life of

Name and Phone of contact in the event we have questions

Danielle Burns, Luke Ramsey: 501.224.7739

Universal Life Policy

- [ ] Current death benefit and premiums
- [ ] Minimum premiums to endow at maturity
- [ ] Minimum premiums to carry to maturity
- [ ] Other specific request

Please allow 7-14 business days from the date of receipt in our office for processing. Thank you.

Please return illustration to:

Name: Danielle Burns, Luke Ramsey
Address: 1807 Hinson Rd Little Rock, AR 72212

Fax: 501-400-8578
Phone: 501-224-7739

Policy Owner Signature

Date

Reassure America Life Insurance Company
(800) 433-9041

I am requesting an Illustration/Reprojection for policy number _____, insuring the life of _____.

Name and Phone of contact in the event we have questions

Danielle Burns or Luke Ramsey 501-224-7739

Term Policy

____ Term to UL conversion
____ Term to WL conversion

Universal Life Policy

☑ Current death benefit and premiums
____ Minimum Premiums to endow at maturity
☑ Minimum Premiums to carry to maturity
☑ Other specific request
No premium going forward
See attached sheet for additional information

We provide one illustration per policy per year at no charge. Any additional requests require $25.00 fee prior to running the illustration.

I have enclosed a check or money order payable to REASSURE AMERICA LIFE INSURANCE COMPANY for:

✔	First request per year	Free
____	Additional request	$25.00 each
	TOTAL	$0

Please allow 7-14 business days from the date of receipt in our office for processing. Thank you.

Please return illustration to:
Name: Danielle Burns or Luke Ramsey
Address: 11807 Hinson Rd. Little Rock, AR 72212
Fax: 501-400-8578
Phone: 501-224-7739

_____ _____
Policy Owner Signature Date

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607-723-3551 • www.smlny.com

Security Mutual…Your Partner for Life.[SM]

Authorization to Release Information

By signing below you are authorizing Security Mutual Life Insurance Company of New York (Security Mutual) to disclose non-public information about you and your insurance coverage at Security Mutual to the person(s) designated below. You agree to release and indemnify Security Mutual, its directors, officers, and employees from any and all liability for losses, damages, or claims of any type arising out of the actions taken by Security Mutual in releasing such information.

This authorization shall remain valid for one (1) year from the "signature date" appearing below.

You may revoke this authorization by submitting your written revocation to the Home Office of Security Mutual. Your revocation will not become effective until received and recorded in our Home Office.

For my convenience, I (we) hereby authorize Security Mutual Life Insurance Company of New York to release to the below named person(s) (the "Authorized Recipient(s)") any and all information reflected in or relating to the following life insurance policy/annuity contract(s):

Policy/Contract Number(s): _____ **Policyowner(s) Name:** _____

_____ _____

_____ _____

Authorized Recipient (Person you are giving authorization to):

Print Name: Danielle Burns or Luke Ramsey **E-mail Address** PHS@theasagroup.com

Print Address: 11807 Hinson Road **Last four digits of SS#:** X X X - X X-____ |__ _

Little Rock, AR 72212 **Date of Birth** _____

_____ **Daytime Phone Number:** (501) 224 - 7739

Signature of Authorized Recipient _____
(Include title, if applicable)

I agree that a facsimile, photocopy or electronic version of this form is as valid as the original.

Date Signed _____ _____

Policyowner(s) Signature(s): _____ _____

(Include title if applicable) _____ _____

Third Party Witness: _____

---------- PLEASE DO NOT WRITE BELOW THIS LINE ----------

Accepted By:_____ Title: _____ Date: _____

USAA®

usaa.com

LETTER OF AUTHORIZATION FOR CONTRACT INQUIRY

COMPLETE AND RETURN

USAA Number: _____

Contract Number: _____

Insured/Annuitant: _____

Owner's Name: _____

As the owner, I hereby authorize USAA Life Insurance Company or USAA Life Insurance Company of New York to provide information on the above referenced contract to:

Luke Ramsey | Danielle Burns _____

Name of Authorized Person

LIR Specialist _____

_____

DOB

11807 Hinson Rd., Little Rock, AR 72212 501.224.7739

Address Phone Number

The individual named above is permitted to make inquiries regarding the contract number specified above.

_____ _____

Owner Date