CONFIDENTIAL

National Baptist Convention of America, Inc.

ENDOWMENT

FUNDING

PROGRAM

"Helping to Create a Future for Your Church or Ministry!"

PARTICIPANT'S NAME AND ADDRESS:

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____

PHONE:

NAME: ______________________________

PLEASE LIST ALL CURRENT MEDICATIONS:

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PLEASE MAKE A COMPLETE AND THOROUGH LISTING OF ALL DOCTORS AND HOSPITALIZATIONS IN THE LAST 10 YEARS:

NAME: ________________________ NAME: ________________________
ADDRESS: ______________________ ADDRESS: ______________________
______________________ ______________________
PHONE: ________________________ PHONE: ________________________

NAME: ________________________ NAME: ________________________
ADDRESS: ______________________ ADDRESS: ______________________
______________________ ______________________
PHONE: ________________________ PHONE: ________________________

NAME: ________________________ NAME: ________________________
ADDRESS: ______________________ ADDRESS: ______________________
______________________ ______________________
PHONE: ________________________ PHONE: ________________________

NAME: ________________________ NAME: ________________________
ADDRESS: ______________________ ADDRESS: ______________________
______________________ ______________________
PHONE: ________________________ PHONE: ________________________

(Use other sheet if necessary)

HOSPITAL: ______________________________ DATES: __________________
ADDRESS: ____
REASON FOR HOSPITALIZATION: ____________________________________

HOSPITAL: ______________________________ DATES: __________________
ADDRESS: ____
REASON FOR HOSPITALZATION: ____________________________________

HOSPITAL: ______________________________ DATES: __________________
ADDRESS: ____
REASON FOR HOSPITALZATION: ____________________________________

(Use other sheet if necessary)

Name: ______________________________

Please bring the following information to your confidential interview. It will greatly assist us in completing a quick and thorough application.

DATE OF BIRTH: _______________ SOCIAL SECURITY NUMBER: _____________

GENDER: M or F DRIVER'S LICENSE NUMBER AND STATE OF ISSUE:

________________________________ STATE: ___________

CELL PHONE OR EMAIL INFORMATION: ____________________________________

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CITY, STATE, COUNTRY OF BIRTH: ____

CITIZENSHIP (if other than US): ________________________________

OCCUPATION: ____

EXISTING LIFE INSURANCE: (Amount, Issuer)

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EVER BEEN DECLINED LIFE INSURANCE: Y or N If yes, why?

____

TOTAL YEARLY INCOME: __________ APPROXIMATE NET WORTH: _________

EVER FILED FOR BANKRUPTCY? Y or N
CURRENTLY USE TOBACCO PRODUCTS? Y or N If yes, how much? _____________
EVER USED TOBACCO PRODUCTS? Y or N When quit? ______________________

INTEND TO CHANGE RESIDENCE OR TRAVEL OUTSIDE US OR CANADA? Y or N
FLYING AS A PILOT? Y or N HAZARDOUS SPORTS? Y or N
ANY MOVING VIOLATIONS IN LAST 3 YEARS? Y or N
ANY ARRESTS FOR DRIVING UNDER THE INFLUENCE IN LAST 10 YEARS? Y or N
ANY CRIMINAL OFFENSES? Y or N
ANY OTHER INFORMATION YOU THINK MIGHT BE HELPFUL?

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<u>Return Completed Confidential Information and Mail to:</u>

CORNERSTONE INSURANCE AGENCY
2450 Atlanta Highway
Suite 903
Cumming, GA 30040

<u>For More Information Please Call:</u>

Natalie Malin-Davis or Jayme Sickert at:

(678) 341-3628

Fax: (678) 455– 6397

nmdavis@ciaatlanta.com

Authorization for Release of Health-Related Information to

Advanced Settlements, LLC
AIG/American General
Banner Life Insurance Company
Canada Life Assurance Company
Canada Life Insurance Company of New York
Columbus Life
Coventry First
Empire General Life Assurance Company
First Colony Life Insurance Company
First Penn Pacific
General American
Jefferson Pilot
John Hancock
Hartford Life
Lincoln Financial Group
Manufacturers Life Insurance Company
Manufacturers Life Ins Company of New York
Massachusetts Mutual Life
Metropolitan Life Insurance Company
MONY
Nationwide
Pacific Life Insurance Company
Pacific Southwest Financial
Penn Mutual Life Insurance Company
Protective Life Insurance Company
Prudential
Reliastar/ING
Reliastar Life Insurance Company of New York
Security Connecticut
Southland Life
Sun Life Assurance Company of Canada
State Life Insurance Company
Stone Street Capital
The Travelers Insurance Company
Transamerica Occidental Life Insurance Company
Valley Forge Life Insurance Company
West Coast Life Insurance Company
United of Omaha
U.S. Financial
Zurich Life
Other: Phoenix Life Insurance Company; Grayhill LLC; Jackson National Life Insurance Company; ING Group (Internationale Nederlanden Groep)

This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization Date of Birth

_______________________________ ______________

_______________________________ ______________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information concerning me to any of the companies listed above ("the Company") and it's authorized representatives. 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 my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I 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 the address listed on the reverse of this form, Attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers have already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make benefit payments.

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Signature of Proposed Insured, Patient, or Personal Representative Date

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 the address listed on this form.

Doctor Information
(any doctor/hospital visited in the past 10 years)

Doctor's Name	Address	Phone