HIPAA Authorization

I, the undersigned individual, authorize the disclosure of my protected health information ("PHI") defined as follows:

Classes of Persons Authorized to Disclose My Protected Health Information

Classes of Persons Authorized to Disclose My Protected Health Information. I authorize each doctor, hospital, nurse, pharmacy, Pharmacy Benefit Manager, physician, physician practice group, laboratory and any other type of health care provider (each, an "Authorized HCP") having any PHI about me to disclose any and all of my PHI as provided under this authorization. I acknowledge that all of my PHI in the possession or control of any Authorized HCP is necessary for the purpose for which this authorization is given as described below. I authorize each Authorized HCP to rely upon a photostatic or facsimile copy or other reproduction of this authorization.

Classes of Persons Authorized to Receive My Protected Health Information

I authorize each Authorized HCP to disclose my PHI under this authorization to any owner of a life insurance policy in which I am the insured, and any of their agents, employees, contractors and representatives, and their respective successors and assigns (each, an "Authorized Recipient") including ITM TwentyFirst, a life expectancy provider.

Definition of Protected Health Information Authorized for Disclosure and Purpose of Disclosure

This authorization shall apply to any and all of my health and medical data, information and records, whether or not personally or individually identifiable or protected under any federal or state confidentiality or privacy laws or regulations, including information relating to psychiatric conditions, AIDS/HIV and/or drug or alcohol abuse/treatment. The purposes of this authorization and all disclosures of my PHI made hereunder are for allowing the Authorized Recipient (a) to analyze, assess, evaluate or underwrite my health or medical condition, or life expectancy, and (b) to monitor, track or verify my health or medical status and condition in connection with the analysis, assessment, or evaluation.

Expiration of Authorization

This authorization shall remain valid until, and shall expire on, the date that is six (6) months after the date of my death.

Right to Revoke Authorization

I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery to ITM TwentyFirst, LLC, Compliance Officer, 333 South 7th Street, Suite 300, Minneapolis, MN 55402; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

Inability to Condition Treatment, Payment, Enrollment or Eligibility for Benefits on Provision of Authorization

I understand that no Authorized HCP or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized HCP to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below and that all information contained in this authorization is true and correct. I further certify that this authorization is written in plain language and that I have received and retained a copy of this signed authorization for future reference.

Signature: _____

Insured's Name: _____ Date: _____

Social Security Number: _____ - _____ - _____

Medical History Questionnaire

Insured's Name: _____

Insured's Date of Birth: _____ Insured's SSN: _____

Gender: ☐ Male ☐ Female Zip Code _____

Current height: _____ Current weight: _____

Family Medical History (check all that apply)

Condition	Father	Mother	Siblings	Child(ren)	Unspecified
Heart Disease (diagnosed before age 61)					
Heart Disease (diagnosed at age 61 or older)					
Stroke (diagnosed before age 61)					
Stroke (diagnosed at age 61 or older)					
Cancer					
Diabetes					
Dementia/Alzheimer's Disease					
Lived to age 85					
Lived to age 95					

Social Habits (check all that apply)

Tobacco Use: ☐ Current tobacco ☐ Discontinued tobacco (date _____) ☐ Never used tobacco.

Alcohol Use: ☐ No alcohol ☐ Occasional Alcohol (# of drinks per day _____)

☐ Past treatment for alcohol or been advised to decrease alcohol (date _____)

Activity Level (choose one)

☐ Retired

☐ Work Outside of the home ocupation _____

☐ Exercise - (choose activity) ☐ Walk ☐ Run ☐ Golf ☐ Swim ☐ Tennis ☐ Other: _____

How often do you exercise: _____

Cardiovascular Risk Factors (check all that apply)

☐ Hypertension

☐ Hyperlipidemia (elevated cholesterol)

☐ Diabetes:

☐ Type 1 ☐ Type 2

Cardiovascular Diagnoses (check all that apply)

☐ No history of CAD (Coronary Artery Disease/Heart Disease)

☐ CAD diagnosed (If checked, please check/respond to questions below.)

☐ Surgery for CAD (CABG or Stenting) Date?

☐ Myocardial Infarction/Heart Attack history (date _____)

Cardiac Structure and Function (check all that apply)

☐ Echocardiogram - current ejection fraction (pumping power of the heart):

_____% or Unknown _____

☐ Pulmonary hypertension

☐ Mild to Moderate ☐ Severe

☐ Chronic congestive heart failure has been diagnosed

☐ Other significant cardiac issues. Please describe: _____

_____

_____

Valvular Heart Disease (check all that apply)

☐ Mitral valve insufficiency

☐ Mild to Moderate ☐ Severe

☐ Aortic valve insufficiency

☐ Mild to Moderate ☐ Severe

☐ Aortic stenosis

☐ Mild to Moderate ☐ Severe

☐ Valve replacement If check, please note date: _____

_____

_____

Arrhythmias (check all that apply)

☐ Pacemaker (slow rate diagnosed)

☐ Defibrillator (fast heart rate diagnosed)

☐ Chronic atrial fibrillation

Cerebrovascular Disease (check all that apply)

☐ One TIA and/or mild stroke with full recovery – no residual effects

☐ Multiple TIA's and or significant stroke with residual effects:

☐ Speech Impairment ☐ Muscular Impairment ☐ Memory Issues

☐ Carotid Artery Disease - at least 50% or more stenosis of carotid arteries

Peripheral Vascular Disease and Disease of the Aorta (check all that apply)

☐ Peripheral Vascular Disease of the lower extremities – blockage of arteries in the legs

☐ Diagnosis of an Abdominal Aortic Aneurysm

Has it been repaired? ☐ Yes ☐ No

Pulmonary (check all that apply)

☐ Shortness of breath with minimal exertion

☐ Diagnosis of COPD (Chronic Obstructive Pulmonary Disease) or Emphysema

☐ Mild ☐ Moderate ☐ Severe

☐ Dependent on supplemental oxygen

Renal/Genitourinary (check all that apply)

☐ Chronic renal insufficiency (kidney disease)

☐ Mild to Moderate ☐ Severe

☐ Requires Dialysis

☐ Other significant genitourinary issues. Please describe: _____

_____

_____

Gastrointestinal (check all that apply)

☐ Dysphagia (difficulty swallowing)

☐ Mild to Moderate ☐ Severe

☐ Ulcerative colitis/Crohn's disease

☐ Diagnosed with chronic hepatitis B or C

☐ Cirrhosis diagnosed

☐ Early stages ☐ Advanced with stigmata of liver disease

☐ Other significant GI issues. Please describe: _____

_____

_____

Hematology (check all that apply)

☐ Current anemia or chronic anemia including B12 deficiency

☐ Diagnosis of Platelet disorder including thrombocytopenia or thrombocytosis

☐ CLL has been diagnosed (chronic lymphocytic leukemia)

☐ Stage 0 ☐ Stages 1, 2 or 3 ☐ Stage 4 or earlier stages requiring treatment

☐ Other significant hematological disorders. Please describe: _____

_____

_____

Cancer

Include melanoma, but no other skin cancers here.

1st Cancer diagnosis:

Primary cancer type: _____

Stage: ☐ In situ ☐ Stages 1 ☐ Stage 2 ☐ Stage 3 ☐ Stages 4 ☐ Unknown

Date of Diagnosis: _____

Date of last treatment: _____

Type of treatment (circle all that apply): ☐ Chemo ☐ Radiation ☐ Wait and Watch

☐ Surgery ☐ Organ removal: _____

Any evidence of recurrence or metastasis? ☐ Yes ☐ No

2nd Cancer diagnosis:

Primary cancer type: _____

Stage: ☐ In situ ☐ Stages 1 ☐ Stage 2 ☐ Stage 3 ☐ Stages 4 ☐ Unknown

Date of Diagnosis: _____

Date of last treatment: _____

Type of treatment (circle all that apply): ☐ Chemo ☐ Radiation ☐ Wait and Watch

☐ Surgery ☐ Organ removal: _____

Any evidence of recurrence or metastasis? ☐ Yes ☐ No

☐ Non melanoma skin cancers (BCC or SCC): _____

_____

_____

Neurologic/Psychiatric (check all that apply)

☐ Cognitive dysfunction (Memory Issues):

- ☐ Cognitive impairment (Early Stages)
- ☐ Mild dementia/Alzheimer's
- ☐ Advanced dementia/Alzheimer's
  Age dementia diagnosed: _____

☐ Multiple Sclerosis

☐ Parkinson's disease

☐ Neuropathy

☐ Current symptoms/treatment of depression/anxiety

☐ Mild ☐ Moderate to Severe Depression ☐ Psychosis

Orthopedic/Rheumatologic/Autoimmune (check all that apply)

☐ Diagnosed with rheumatoid arthritis

☐ Diagnosed with osteoarthritis or DJD of back or knees

☐ Spinal issues associated with DDD, stenosis, sciatica or radiculopathy

- ☐ Surgery Required

☐ Osteoporosis ☐ Osteopenia

Functional Status (check all that apply)

☐ Recurrent episodes of dizziness

☐ Recurrent syncopal episodes (fainting)

☐ Chronic fatigue, weakness, frailty

☐ Gait or balance disturbance

☐ Two or more falls within the past five years. Dates of occurrence: _____

☐ Any use of an assistive device (cane, walker, brace) for ambulation

☐ ADL deficiencies:

- ☐ Require assistance with walking
- ☐ Require assistance with transfers
- ☐ Require assistance with bathing
- ☐ Require assistance with toileting
- ☐ Require assistance with dressing
- ☐ Require assistance with eating

Infectious Disease (please complete this section if you have been diagnosed as having HIV or AIDS)

Please check all of the following descriptors that apply:

☐ Diagnosed less than 15 years ago

☐ Diagnosed 15 or more years ago

☐ History of intravenous (IV) drug use at any age

☐ History of significant opportunistic infections (not thrush, candidiasis) any any age

☐ Diagnosis of AIDS at any age

☐ CD4 count has dropped below 200 at any age

Have you been hospitalized in the last 5 years? If yes, why?

☐ No

☐ Yes _____

_____

_____

Magna
LIFE SETTLEMENTS

Additional Information

Please use this section to tell us anything else of significance about your health. _____

_____

_____

_____

List of Medications being taken

Name of Medication	Dosage of Medication	Reason for taking

Primary Physician's Name: _____

Date last seen: _____

Primary Physician's Address: _____

City_____ State _____ ZIP _____

LU-11/02/2016