AUTHORIZATION FOR RELEASE OF INFORCE POLICY INFORMATION

Policy Owner Name: _____
Social Security or Tax ID#: _____

(If Trust Owned)
Full Name of Trust: _____ Trustee's Name: _____
Trust ID#: _____ Date of Trust: _____ Insured's Name: _____

I hereby authorize Business Underwriters Associates, Christina M. Carley, and the BUA staff, to obtain and/or request information regarding my existing life insurance policy(s) listed below. This information shall include but not be limited to, in-force ledgers, policy dates; cash value information, interest/dividend history, and underwriting classifications.

Insured Date of Birth: _____
Insurance Carrier: _____
Policy Number(s): _____
Policy Issue Date: _____

The information above will be held in confidence. The policy data collected may be reviewed and assessed by qualified personnel consisting of medical, underwriting, and actuarial resources or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of Business Underwriters Associates, affiliated insurance companies and their reinsurers. The records may be transmitted via U.S. regular mail, various overnight mail services and/or through the use of secured electronic devices.

This authorization shall be valid for six (6) months from the date below. A copy of this authorization shall be valid as the original. I understand that I am entitled to receive a copy of this authorization, and I understand that I may revoke this authorization at any time and that the revocation will take effect when my Representative receives my written request.

Signed on the _____ day of _____, year of, _____ city/state.
Insured Signature: _____
Owner Signature (if other than insured): _____

Agent/Representative
Name (please print): _____
Signature: _____

Please email a PDF of this completed form to your BUA Brokerage Sales Manager!
Or fax with a cover page to 330.576.1128

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