

Authorization to Release Information

Insured 1:	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: (mm/dd/yyyy)	<input style="width: 95%;" type="text"/>
Insured 2:	<input style="width: 95%;" type="text"/>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Date of Birth: (mm/dd/yyyy)	<input style="width: 95%;" type="text"/>
Trustee Name(s):	<input style="width: 95%;" type="text"/>			Date of Trust: (mm/dd/yyyy)	<input style="width: 95%;" type="text"/>
Policy Owner:	<input style="width: 95%;" type="text"/>			Policy Owner's Federal Tax ID:	<input style="width: 95%;" type="text"/>
Insurance Carrier:	<input style="width: 95%;" type="text"/>	Face Amount:	<input style="width: 95%;" type="text"/>	Policy No.:	<input style="width: 95%;" type="text"/>

A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS VALID AS THE ORIGINAL

By my signature below, I hereby authorize the above insurance carrier, the issuer of the policy referenced above, to release to: **(1) Insurance Trust Monitor, Inc. and (2) Investment Scorecard, Inc. any and all information requested on this policy.** (If this policy is a group plan governed by the Employment Retirement Income and Security Act [ERISA], this authorization is the policy owner's request to the extent required by Insurance Trust Monitor, Inc. or Investment Scorecard, Inc. to obtain copies of all Benefit Plan documents pertaining to the life insurance policy.) This shall include, but not be limited to: a copy of the complete life insurance contract, including the application for insurance; copies of annual statements and other policy change documents; the as sold illustration; current illustrations; and a completed Policy Review Questionnaire.

In addition, the insurance carrier's representatives are authorized to discuss the above referenced policy with Insurance Trust Monitor, Inc. and Investment Scorecard, Inc. This form **does not** authorize Insurance Trust Monitor, Inc. and Investment Scorecard, Inc. to exercise any other rights of policy ownership. **The information released under this authorization is to be faxed directly to Insurance Trust Monitor, Inc. at: 319-277-3642. If you are unable to fax, then it is to be mailed to: Insurance Trust Monitor, Inc., 809 W. 1st Street, Suite B, Cedar Falls, IA 50613.**

This authorization shall remain valid for the maximum period allowed under applicable state law unless and until such time as I advise the insurance carrier in writing of its revocation. Further, by signing this Authorization, I hereby relieve, release and forever discharge the insurance carrier referenced above, its successors, parents, representatives, affiliates, agents, officers, directors, employees, and assigns ("Releasees") from any and all causes of action, suits, controversies, claims, demands and damages of any kind or character whatsoever against said Releasees in any way related to this release of information.

Dated: (mm/dd/yyyy)

Policy Owner's Signature

Witness' Signature

Printed Name

Printed Name:

Title & Policy
Owner:

Title:

Insurance Trust Monitor, Inc. • 809 W 1st Street, Suite B • Cedar Falls, IA 50613
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