AGENTS INSURANCE SERVICES of AMERICA, Inc.

Telephone: (760) 435 9702

LAB RESULTS REQUEST
and/or
MEDICAL INFORMATION RELEASE REQUEST

Insured's Name:_____ Policy #:_____

I hereby authorize: _____ to:
(Insurance Company)

Please check off one of the following:

- Provide Reasons for a policy offer that is other than applied for.
- Release my lab results to me.
- Release medical information to me.
- Release medical information to the designated medical professional listed below:

Name and address of person or physician to whom above requested information should be sent:

_____

_____

_____

This authorization will expire six months after receipt by Underwriting Solutions.

_____ _____
Date Signature

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EMAIL – Und Solutions@cs.com