INNOVATIVE HEALTH PLAN

AUTHORIZATION AND DISCLOSURE FORM

To Whom It May Concern:

I hereby authorize and request any present or former employer, school, consumer reporting agency, financial institution, law enforcement agency, city, state, county and federal court and agency, military service or other persons having personal knowledge about me, to furnish bearer with any and all information in their possession regarding me in connection with my application for appointment as an insurance agent.

I am willing that a photocopy of this authorization be accepted with the same authority as the original, and I specifically waive any written notice from any present or former employer who may provide information as a result of this authorization.

I release Innovative Health Plan, LLC and any person or organization complying with this authorization from any liability in connection with information furnished pursuant to this authorization.

I understand that this Authorization is to be part of the Appointment Request completed by me.

Date: _____

Print Name: _____

Signature: _____

For Identification Purposes Only:

Date of Birth: _____

Social Security Number: _____

Current Street Address: _____

City, State, Zip Code: _____

If name changed (through marriage or otherwise), former name:

_____