PRELIMINARY INQUIRY – NOT AN APPLICATION FOR LIFE INSURANCE 09/13

PERSONAL HISTORY

Name _____ ☐ Male ☐ Female Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Business Phone: _____

Date of Birth _____ Age _____ Height _____ Weight _____ Monthly Earned Income _____

Occupation _____ What are your duties? _____

When last used tobacco? Cigarettes _____ Cigars _____ Other _____

Hazardous Activities: Private Pilot: ☐ Yes ☐ No Scuba Diving: ☐ Yes ☐ No Sky Diving: ☐ Yes ☐ No

MEDICAL HISTORY – THIS SECTION MUST BE FULLY COMPLETED

1. Who is your personal physician?	Doctor's name, address and phone number	When did you last consult him/her? Date	Illness
2. What other physicians have you consulted during the past five years? (Do no t include insurance examinations)			
3. In what clinics, hospitals, or sanitariums have you ever been treated?			
4. Please list all current medications:			

Please be specific with above information & include phone numbers. It will expedite processing.

Has any person to be covered had or been told he or she had:		Yes	No
A	Epilepsy, fainting spells, nervous or mental condition, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?		
B	Heart attack, murmur, palpitation, or high blood pressure, anemia, varicose veins, or any disease or abnormality of the heart, blood, or blood vessels?		
C	Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?		
D	Ulcer, indigestion, colitis, gall stones, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, or liver?		
E	Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital systems?		
F	Diabetes, gout, or any disease or abnormality of the thyroid or other glands?		
G	Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?		
H	Any disease or abnormality of the eyes, ears, or skin?		
I	Cancer or tumor?		
J	Any physical deformity or defect?		
K	An immune deficiency disorder, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection?		

TRAVEL

1. Have you traveled in the past 5 yrs OR do you intend to travel outside the United States in the next 5 yrs? Yes____ No____

2. If YES, where did you travel in the past 5 yrs, when and for how long OR where do you intend to travel, when, and for how long?

Within the past ten years, has any person to be covered used:

		Yes	No
A	Amphetamines, barbiturates, sedatives, or morphine or any other narcotic drug except as prescribed by a physician?		
B	Cocaine, heroin, marijuana, PCP, LSD, or any other hallucinogenic drug?.....		
A	Have any close relative of any person to be covered ever had cancer, diabetes, heart disease, or a nervous or mental abnormality?		
B	Has any person to be covered ever received treatment or joined an organization for alcoholism or drug addiction?		
C	Is any person to be covered now pregnant?		

REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship

Face amount desired $ Premium Amount desired $ ☐ Annually ☐ Monthly

What will be the purpose of the insurance? Name of beneficiary Relationship

WHAT ADVERSE ACTION OR TABLE RATING WAS OFFERRED BY ANOTHER COMPANY?

Did your primary company work this case? ☐ Yes ☐ No

Company	Date	Amount	Action	Current Premium	Total

Is this case being considered by another Impaired Risk Agency? ☐ Yes ☐ No

OTHER INSURANCE ON PROPOSED INSURED

Total amount in force _____ Date of last application _____ Is this insurance applied for to replace insurance? ☐ Yes ☐ No

Name of Company If so, premium being replaced

AGENT INFORMATION

Name _____ Firm Name _____ SS# _____ ☎ _____

Address _____ City _____ State _____ Zip _____

HAVE ATTACHED AUTHORIZATIONS SIGNED SO THAT POLICY INFORMATION AND MEDICAL RECORDS CAN BE OBTAINED

Fax your completed documents to: 610-239-6304 Attn.: UNDERWRITING

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: _____

THE COMPANIES		
AIG Life Insurance Company	Koresko Financial, LP / INSMAX	Sun Life
Amrita Financial	Lincoln Financial Group	Transamerica
American General	Met Life	United of Omaha / Mutual of Omaha
American National	MONY Life Insurance Company	Minnesota Life
Ashar Group	New York Life Insurance Company	North American (NACOLAH)
Aviva	Nationwide Life	
AXA	Old Mutual Life Insurance Co.	West Coast Life
Freedom Brokers, LLC	Pacific Life Insurance Co.	Hartford
Banner Life	Kemper	
Coventry First, LLC	Protective Life Insurance Co.	Foresters
First Penn Pacific	Prudential	Fidelity Life
Genworth	ReliaStar Life Insurance Co.	SBLI
John Hancock Life Insurance	Life Settlement Solutions Inc.	William Penn
ING	Peachtree Settlement Funding	One America / State Life
Life Settlement Solutions	Symetra	Penn Mutual
Lincoln Benefit	Lafayette Life (Western & Southern)	Principal Life and Principal National Life Insurance Co.
National Life Group (LSW)	Allianz	
Motorist Life	Columbus Life	ReliaStar Life Insurance Co. of NY
Guardian	Medical Underwriters including but limited to	AVS, 21st Services, Fasano & EMSI

The terms that follow have the respective meanings when used in this Authorization:

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency

BUREAU: Medical Information Bureau, Inc.

AUTHORIZATION: Authorization to Obtain and Disclose Information

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits;

If for a Lifetime Settlement, I understand that settlement providers and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner, or which I am the insured, and I hereby expressly authorize such use and disclosure

Signed at _____ this _____ day of _____ 20____

_____ Proposed Insured Signature

_____ Proposed Owner's Signature

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

_____ Name of Minor Child

_____ Signature of Minor Child's Authorized Representative

_____ Name of Minor Child's Authorized Representative

_____ Witness (Broker)

Authorization for Release of Health-Related Information & Personal Psychotherapy Notes
This authorization complies with the HIPAA Privacy Rule

_____ _____
Name of Persons covered by this Authorization Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 15 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured, Patient, or Personal Representative Date

x

Description of Personal Representative's Authority or Relationship to Patient