PRELIMINARY INQUIRY – NOT AN APPLICATION FOR LIFE INSURANCE

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 not include insurance examinations.*)			
3. In what clinics, hospitals, or sanitariums have you ever been treated?			

4. Please list all current medications, include instructions on dosage and prescribed reason for medication:

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

Has any person to be covered had or been told he/she had (*circle all that apply and a brief summary*):

		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 (include angioplasty, # of stents, etc.), 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 (provide PSA, if known), urinary or genital systems?	____	____
F.	Diabetes (provide A1C, if known), 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?	____	____

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TRAVEL

1. Have you traveled in the past 5 years OR do you intend to travel outside the United States in the next 5 years? **Yes** ____ **No** ____

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

Within the past ten years, has any person to be covered used (*circle all that apply*):

		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?	____	____
C.	Have any close relative of any person to be covered ever had cancer, diabetes, heart disease, or a nervous or mental abnormality?	____	____
D.	Has any person to be covered ever received treatment or joined an organization for alcoholism or drug addiction?	____	____
E.	Is any person to be covered now pregnant? .... If **YES**, what is the anticipated due date?	____	____

REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED

☐ Index UL/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 Spouse

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

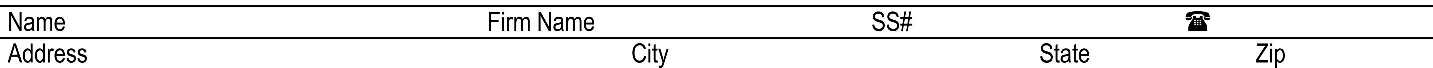
Is this case being considered by another Impaired Risk Agency? ☐ Yes ☐ No

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

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: ______________________________

THE COMPANIES:	
Advantage Insurance Network (AIN)	2801 Townsgate Road, Suite 350, Westlake Village, CA 91361
Allianz Life Insurance Company of North America	P.O. Box 59060, Minneapolis, MN 55459-0060
American National Insurance Company American National Life Ins. Co. of New York	One Moody Plaza, Galveston, Texas 77550-7947 344 Route 9W, Glenmont, NY 12077
Ameritas Life Insurance Company and Ameritas Life Insurance Corp. of New York	P.O. Box 81889, Lincoln, NE 68501
Banner Life Insurance Company	3275 Bennett Creek Ave., Frederick, MD 21704
Brighthouse Financial Insurance Company	1209 Orange St., Wilmington, DE 19801
Brighthouse Life Insurance Co. of NY	New York, New York 10017
Corebridge Financial Corebridge Financial (USL)	2727-A Allen Parkway, Houston, Texas 77019 28 Liberty St., 45th Floor, New York, NY 10005-1400
Equitable Financial Life Insurance Company and Equitable Financial Life Ins. Co. of America	P.O. Box 1047, Charlotte, NC 28201-1047
Fidelity & Guaranty Life	801 Grand Ave., Des Moines, IA 50309-8000
First Symetra National Life Insurance Company of NY	420 Lexington Avenue, Suite 300, New York, NY 10170-0399
Foresters	789 Don Mills Road, Toronto, Ontario M3C1T9
John Hancock Life Ins. Co. (U.S.A) and John Hancock Life Ins. Co. of New York	410 University Avenue, Suite 55765, Westwood, MA 02090
Lafayette Life Insurance Co. (non-NY only)	400 Broadway, Cincinnati, OH 45202-3341
Life Ins. Co. of Southwest (National Life Group)	One National Life Drive, Montpelier, VT 05604
Lincoln Financial Group, Lincoln National Life Insurance Company and Lincoln Life & Annuity Co. of New York	P.O. Box 21008, Greensboro, NC 27420-1008
Massachusetts Mutual Life Ins. Co. (MassMutual)	1295 State Street, Springfield, MA 01111-0001
Minnesota Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
Mutual of Omaha Insurance Co.	3330 Mutual of Omaha Plaza, Omaha, NE 68175
National Life of Vermont (National Life Group)	One National Life Drive, Montpelier, VT 05604
Nationwide Life Insurance Company and Nationwide Life and Annuity Insurance Company	P.O. Box 182928, Columbus, OH 43218-2928
New York Life Insurance Company	1140 Tomahawk Creek Parkway, Ste. 200, Leawood, KS 66211
North American Company for Life & Health Insurance	P.O. Box 5088, Sioux Falls, SD 57117
OneAmerica – The State Life Insurance Company	One American Square, P.O. Box 368, Indianapolis, IN 46206-0368
Pacific Life Insurance Company and Pacific Life and Annuity Company	P.O. Box 2030, Omaha, NE 68103-2030
Pacific Life Insurance Company (Lynchburg)	P.O. Box 2869, Omaha, NE 68103
Principal Life Insurance Company and Principal National Life Insurance Company	P.O. Box 14455, Des Moines, IA 50306-3455
Protective Life Insurance Company and Protective Life and Annuity of New York	P.O. Box 830619, Birmingham, AL 35283-0619
Prudential Insurance Company of America, Pruco Life Insurance Co. (except in NY), and Pruco Life Insurance Co. of New Jersey (in NY and NJ)	Attn: Underwriting, 13001 County Road 10, 4th Floor, Plymouth, MN 55442
Securian Life Insurance Company	400 Robert Street North, St. Paul, MN 55101-2098
Symetra Life Insurance Company	777 108th Ave NE, Suite 1200, Bellevue, WA 98004-5135
Transamerica Financial Life Insurance Company Transamerica Life Insurance Company	440 Mamaroneck Avenue, Harrison, NY 10528 6400 C Street SW, Cedar Rapids, IA 52499
United of Omaha Life Insurance Company	3330 Mutual of Omaha Plaza, Omaha, NE 68131
William Penn Insurance Company of New York	3275 Bennett Creek Ave., Frederick, MD 21704

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (continued)

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;

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 - 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 10 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

Date
Signature of Proposed Insured, Patient, or Personal Representative
x

Date
Signature of Proposed Insured, Patient, or Personal Representative
x

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of 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 10 years (“My Providers”) to disclose my entire medical record and any other personal health information solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as “The Companies”). 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 conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

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 as described above 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.

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Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Signature of Proposed Insured, Patient, or Personal Representative | Date

x ____

Description of Personal Representative’s Authority or Relationship to Patient

x ____