

**Informal Inquiry**  
*(not an application)*

<b>A. PROPOSED INSURED</b>	1. Name of Proposed Insured (First, Middle, Last)			2. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		3. Date of Birth Month Day Year		
	4. Social Security No. — —		5. Birth Place.		6. Citizen of (Country)		7. Drivers License State and No.	
	8. Residence: Street			City			State Zip	
	9. Occupation			10. Duties			11. Phone No. ( )	
	12. Current Income				13. Current Net Worth			
<b>B. PLAN OF INSURANCE</b>	1. Amount applied for with Penn Mutual _____ Plan _____							
	2. What is the need and purpose of the coverage? _____							
	3. Within the last 12 months, has coverage (including Informal Inquiries) been applied for with other companies? <input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, list all companies, amounts, and offers received _____							
	4. Who will be the owner of the policy? <input type="checkbox"/> Insured <input type="checkbox"/> Trust <input type="checkbox"/> Business <input type="checkbox"/> Organization <input type="checkbox"/> Other							
<b>C. REASON FOR INQUIRY</b> <small>Please advise why this is being submitted as a Preliminary Inquiry. What outcome do you expect?</small>	Why has this been submitted as an Inquiry? <input type="checkbox"/> Medical History <input type="checkbox"/> Previous Adverse Underwriting <input type="checkbox"/> Trust not completed <input type="checkbox"/> Loan/Financing not completed <input type="checkbox"/> Other _____							
<b>D. PREMIUM FINANCING DETAILS</b>	1. Will any part of the premium be paid from funds that are borrowed or otherwise financed? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	2. Has there been any discussion about the possible sale or assignment of this policy to a Life Settlement, Viatical or other secondary market provider? <input type="checkbox"/> YES <input type="checkbox"/> NO							
	3. Within the past 2 yrs, has the Proposed Insured sold a policy to a Life Settlement, Viatical, or other secondary market provider? <input type="checkbox"/> YES <input type="checkbox"/> NO Provide full details for any Yes answers: _____							
<b>E. TOBACCO USAGE</b>	1. Has Proposed Insured <b>ever</b> used tobacco or nicotine products in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No							
	2. If "Yes": Type _____ Frequency _____ Date Last Used _____							
<b>F. AGENT INFORMATION</b>	1. Agent Name			2. Agent/Office Code(s)				
	3. Agent Signature				4. Date			
<b>G. TO BE COMPLETED BY FIELD OFFICE</b>	Policy Number _____							
	Indicate Rate Class Desired: <input type="checkbox"/> Standard or Better <input type="checkbox"/> Table 2 - 4 <input type="checkbox"/> Table 4 & above <input type="checkbox"/> Any possible offer							
	The following documents are included: <i>(Check all that apply)</i> <input type="checkbox"/> APS <input type="checkbox"/> Medical Summary <input type="checkbox"/> Exam <input type="checkbox"/> Lab Results <input type="checkbox"/> HIPAA Authorization (required)							
<b>IMPORTANT: If medical records are not being submitted, section F &amp; H <i>must be completed.</i></b>								

**H. PERSONAL AND MEDICAL INFORMATION (Continued)**

Provide details to any yes answers in the "Details" section.

Only complete if APS or other supporting medical information is not available.

Section H must also be completed.

1. Give full name and address of your personal physician. If no personal physician, give full name and address of last physician consulted. *(Include dates and reasons why either was consulted.)*

- |                                                                                                                                                       |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 2. Have you ever been treated for or had any indication of:                                                                                           | Yes                      | No                       |
| (a) Disorder of eyes, ears, nose or throat?                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Epilepsy, fainting, convulsions, frequent headaches; paralysis or stroke; mental or nervous disorder?                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Shortness of breath, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or circulatory system?   | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Jaundice, intestinal bleeding, ulcer, hernia, colitis, recurrent indigestion or other disorder of the stomach, intestines, liver or gall bladder? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Sugar or albumin in urine; stone or other disorder of kidney, bladder, prostate, reproductive organs or breasts?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Diabetes; thyroid or other glandular disorder?                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| (h) Arthritis, gout, or disorder of muscles, bones or joints?                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |
| (i) Deformity, lameness or amputation?                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| (j) Disorder of skin, lymph glands; cyst, tumor or cancer?                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| (k) Allergies; anemia or other disorder of the blood?                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |

INSTRUCTIONS: Give details for all "Yes" answers. (IDENTIFY QUESTION NUMBERS. CIRCLE APPLICABLE ITEMS. Give the diagnoses, dates, treatment, duration of illness and names and addresses of all attending physicians and medical facilities.)

Height: \_\_\_\_\_ Ft. \_\_\_\_\_ In.

Weight: \_\_\_\_\_ Lbs.

3. Have you ever:
- |                                                                                       |                          |                          |
|---------------------------------------------------------------------------------------|--------------------------|--------------------------|
| (a) Habitually used amphetamines, barbituates, hallucinogens, marijuana or narcotics? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Been counselled or treated for the excessive use of alcohol or drugs?             | <input type="checkbox"/> | <input type="checkbox"/> |

4. Have you within the past 5 years:
- |                                                                                                   |                          |                          |
|---------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| (a) Had a checkup or physical examination?                                                        | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Been a patient in a hospital or other medical facility or had any type of surgery?            | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Had an electrocardiogram or other diagnostic tests?                                           | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Been advised to have any diagnostic test, hospitalization or surgery which was not completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Had any disease or injury not listed above?                                                   | <input type="checkbox"/> | <input type="checkbox"/> |

5. Are you presently under medical observation or taking any medication?

6. Have you ever had military service deferment, rejection or discharge because of a physical or mental condition?

7. Any family history of diabetes or heart disease?

8. Family history	Age if living	State of health	Age at death	Cause of death
Father				
Mother				
Brothers and Sisters				
No. living <input type="text"/>				
No. dead <input type="text"/>				

**I. INSURED**

Only required when supporting medical information is not available (i.e. APS, Medical Summary) and section F is completed. Must complete section F of this form.

1. Insured Name

2. Insured Signature

3. Date

## AUTHORIZATION TO OBTAIN & DISCLOSE INFORMATION

Aetna Life Insurance Co.	Coventry First	John Hancock Life of NY		Southwestern Life Ins. Co.
Allianz Life	Continental Assurance	Kansas City Life	Ohio National Life Assurance	State Life
Allianz Life of NY	Empire General	Kemper Investors	Ohio National Life Ins.	Sun Life & Annuity
American General	Equitable Life of IA - ING	Lafayette Life	Pacific Life	SunAmerica Life Ins.
American Life Ins. Co.	EquiTrust Life Ins.	Liberty Life	Paul Revere Life	Transamerica Financial Life
American National	Fidelity & Guaranty	Life Investors	Penn Mutual	Transamerica Life
American Skandia	Fidelity & Guaranty of NY	Lincoln Benefit Life	People's Benefit	Transamerica Life & Annuity
AmerUs Life Ins.	First Colony Life	Lincoln Life & Annuity Co. of NY	Phoenix Life	Transamerica Occidental
Assurity Life Ins. Co.	First Penn-Pacific	Lincoln National Life Ins. Co.	Physicians Life Ins. Co.	Travelers Ins. Co.
Aviva Life	General American	MassMutual	Physicians Mutual	Travelers Life & Annuity
Aviva Life Ins. Of NY	Gerber Life	MetLife Invest USA	Presidential Life Ins.	Union Central
AXA Equitable Life Ins. Co.	Great American	MetLife Investors	Principal Life	United of Omaha
Bankers Life of NY	Guarantee Trust Life	Metropolitan Life Ins. Co.	Protective Life	United State Life
Banner Life	Guardian Life	Midland National	Provident Life & Acc.	UNUM Life of America
Boston Mutual	Hartford Life	MML Bay State Life	PRUCO Life Ins. Co.	US Financial
Chase Ins. Life & Annuity	Illinois Mutual	MONY Life Ins. Co.	PRUCO Life of NJ	USG Annuity & Life
Chase Ins. Life of America	ING Life Ins. & Annuity	MONY Life of America	Prudential Financial	Valley Forge Life Ins.
Chase Ins. Life of NY	Integrity Life	National Life Group	Reassure America Life	Viatiscus
Cincinnati Life Ins. Co.	Jefferson Pilot Financial Ins. Co.	Nationwide Life	Reliastar Life - ING	West Coast Life
Clarica Life Ins. - US	Jefferson-Pilot Life Ins. Co.	New England Life Ins. Co.	Reliastar Life of NY - ING	Western Reserve
CM Life Ins. Co.	Jefferson-Pilot LifeAmerica	New York Life	Security Benefit	William Penn of NY
Columbian Mutual	John Alden Life	New York Life & Annuity	Security Life of Denver - ING	
Companion Life of NY	John Hancock Life	North American Co. for L&H	Security Mutual of NY	
Conseco Ins. Co.	John Hancock Life (USA)	North American Co. for L&H NY	Southland Life-ING	

The terms that follow have respective meaning when used in this Authorization.

**INSURANCE SUPPORT ORGANIZATIONS:** Medical Information Bureau, Inc. and/or Consumer Reporting Agency  
**BUREAU:** Medical Information Bureau, Inc.  
**AUTHORIZATIONS:** Authorization to Obtain and Disclose Information

I understand that any Company named above, its re-insurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) re-insurer; (6) insurance support organizations; (7) financial source; and (8) employer, to furnish the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original. To facilitate rapid submission of such information, I authorize all said sources, except Medical Information Bureau, Inc. to give such records or knowledge to The New Jersey Regional Office.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; and (9) other personal traits.

The Companies named above and their re-insurers will use the information in order to determine whether I am insurable. The insurance agent may also use this information to help update and improve my insurance program.

Those parties named in the first paragraph of this Authorization may disclose the information that they have collected. They may disclose this information to (1) other insurers to which I have applied or may apply; (2) re-insurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be allowed by law.

**A photographic copy of this Authorization and acknowledgment shall be as valid as the original. This Authorization will be valid for 30 Months after the date it is signed (two years in R.I.). I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). I understand that I or my authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_,

Signature of Proposed Insured (Parent of proposed insured is a minor)

**Authorization for Release of Health-Related Information to  
AMERICA'S PARTNERS, LLC/SEQUOIA PREMIER PARTNERS/SEQUOIA FINANCIAL  
NETWORK/ADVANTAGE INSURANCE NETWORK/CPS INSURANCE/THE PRODUCERS  
NETWORK**

**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 protected health information concerning me to The Regional Office and its authorized representatives. 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.

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

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

This Authorization shall remain in force for 30 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 at 1030 W. Higgins Rd. Suite 212, Park Ridge, IL 60068, Attention: Underwriting. 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 Company has 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 if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued may not be able to make benefit payments.

---

<b>Signature of Proposed Insured, Patient, or Personal Representative</b>	<b>Date</b>
---------------------------------------------------------------------------	-------------

---

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

---

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

---

Description of Personal Representative's Authority or Relationship to Patient

America's Partners  
847-489-4475  
fax 847-518-0062  
david@americaspartner.com