

**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 requested _____ 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: (Check all that apply) <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 must be completed.</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**

Advantage Insurance Network	Great American	Minnesota Life	Security Mutual of NY
Allianz Life	Guardian Life	Nationwide Life	Sequoia Premier Partners
Allianz Life of NY	Hartford Life	New England Life Ins. Co.	Sun Life & Annuity
America's Partners, LLC	ING Life Ins. & Annuity	New York Life	SunAmerica Life Ins.
American General	Integrity Life	New York Life & Annuity	The Producer's Network
American National	ING Life Ins. & Annuity	North American Co. for L&H NY	Transamerica Financial Life
AmerUs Life Ins.	Integrity Life	Ohio National Life Assurance	Transamerica Life
Aviva Life	John Hancock Life	Ohio National Life Ins.	Transamerica Life & Annuity
Aviva Life Ins. Of NY	John Hancock Life (USA)	Pacific Life	Transamerica Occidental
AXA Equitable Life Ins. Co.	John Hancock Life of NY	Penn Mutual	Travelers Ins. Co.
Banner Life	Kansas City Life	Principal Life	Travelers Life & Annuity
Conseco Ins. Co.	Lafayette Life	Protective Life	Union Central
Coventry First	Liberty Life	Provident Life	United of Omaha
CPS Insurance	Lincoln Benefit Life	Provident Life & Acc.	West Coast Life
EquiTrust Life Ins.	Lincoln Life & Annuity Co. of NY	PRUCO Life Ins. Co.	Western Reserve
Fidelity & Guaranty	Lincoln National Life Ins. Co.	PRUCO Life of NJ	William Penn of NY
Fidelity & Guaranty of NY	MassMutual	Prudential Financial	
First Colony Life	MetLife Invest USA	Reliastar Life – ING	
First Penn-Pacific	MetLife Investors	Reliastar Life of NY – ING	
General American	Metropolitan Life Ins. Co.	Security Benefit	
Gerber Life	Midland National	Security Life of Denver – 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 at 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 above mentioned.

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 this 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 \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
 Name  
 Version 11/09

\_\_\_\_\_  
 Signature (Parent of proposed insured is a minor)

\_\_\_\_\_  
 Date of Birth  
 Page 1 of 1