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INFORMAL APPLICATION

Personal History

Name (First, MI, Last)

☐ Male
☐ Female

Date of Birth (MM/DD/YY)

Social Security No.

Street Address

City | State | Zip Code

Occupation | Net worth | Annual Income

Requested Plan of Insurance

☐Universal Life ☐Whole Life ☐Term, Level Period _____
☐Survivorship

☐Long-Term Care ☐Disability Income

Face Amount Desired: $

Premium Amount Desired: $

Purpose of Insurance | Beneficiary

Rate Class Desired

Pending and In-Force Coverage ■none

Company	Issue Date	Underwriting Class	Face Amount	Type of Insurance	Annual Premium	Cash Value	Replacement ?	1035 Exchange?
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No

Are you working with any other agencies on this case? ☐ Yes _____ ☐ No
Have you received any offers? If so provide details (Carrier, underwriting class, etc.) _____
Are you aware of any other information or special circumstances that could impact underwriting? _____

Agent Information

Name | Agency | Phone Number | Email Address

Street Address | City | State | Zip Code

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Proposed Insured _____

Medical History

Height ____feet ____ inches Weight _____ pounds

Name, Address Primary Physician

Date Last Consulted | Reason Last Consulted

List current medications:

Medical Tests

Test	Date *(Most recent)*	Result (If abnormal provide details)
Blood Pressure		
Cholesterol		Total: _____mg Ratio: _____
EKG		☐Normal ☐Abnormal
Colonoscopy		☐Normal ☐Abnormal
Mammogram		☐Normal ☐Abnormal
PSA (men) Prostate Specific Antigen		☐Normal ☐Abnormal

Details:

Medical Conditions

Have you ever had the following conditions?

1. Chest Pain, Coronary Heart Disease, any disorder of the heart?..... ☐ Yes ☐ No
   a. Heart Attack? ☐ Yes, Date _____ ☐ No
   b. Angioplasty? ☐ Yes, Date _____ ☐ No How many arteries involved? _____
   c. Bypass? ☐ Yes, Date _____ ☐ No How many arteries involved? _____
   d. Valve Replacement? ☐ Yes, Date _____ ☐ No Details _____
   e. Arrhythmia, enlarged heart, heart murmur or any other disorder/disease of the heart? .....☐ Yes ☐ No

Details _____

_____

2. Cancer, Tumor, cyst or growth? ..... ☐ Yes ☐ No
   a. If yes, Date: _____ Location: _____ Stage _____ Grade _____
   b. Type of treatment: ☐ Surgery ☐ Radiation ☐Chemo ☐Hormone therapy ☐ Other _____
   c. Metastasis? ☐ Lymph Nodes ☐ Other Organs _____ Recurrence? ☐ Yes _____ ☐ No

3. Diabetes? .....☐ Yes ☐ No
   a. If yes, date of diagnosis: _____ Treatment: ☐ Diet only ☐ Oral Medication ☐ Insulin
   b. Dosage & Details _____
   c. Blood Glucose Levels: Checked at home? ☐ Yes ☐ No Results _____
   d. Last A1C: Date ____ Result _____ Last Glycohemoglobin level: Date_____ Result _____mg%
   e. Ever had protein in the urine, eye trouble, microalbumin in urine, neuritis/neuralgia or insulin reactions? If yes, provide details _____
      _____

Proposed Insured _____

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Medical Conditions Continued

4. High blood pressure, stroke or any other disease of the blood vessels? ☐ Yes ☐ No
5. Asthma, bronchitis, emphysema, tuberculosis , any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
6. Seizure, paralysis, headaches, multiple sclerosis, any other disorder of brain/nervous system? ☐ Yes ☐ No
7. Chronic fatigue, stress, depression, anxiety or any other emotional or psychological disorder? ☐ Yes ☐ No
8. Hepatitis, colitis, ulcer, cirrhosis, irritable bowel, any other disease or disorder of the liver, gallbladder, pancreas or digestive tract? ☐ Yes ☐ No
9. Kidney stones, nephritis, sexually transmitted disease, any disorder of the urinary or reproductive system? ☐ Yes ☐ No
10. Back or neck pain, disc problems, spinal sprain or strain, sciatica, arthritis, any other disease or disorder of the bones, joints, or muscles? ☐ Yes ☐ No
11. Borderline diabetes, sugar in the urine, thyroid disorder or any other disorder of the glandular system? ☐ Yes ☐ No
12. List any other disease or disorder not previously mentioned _____

_____

Family History

Has any immediate family member (parents, siblings) been diagnosed with or died from complications from heart disorders, diabetes, cancer or circulatory disorder? ☐ Yes ☐ No (if yes, complete chart)

	Age (if living)	Age at death	Age at diagnosis	Details
Father				
Mother				
Brothers				
Sisters				

Activities/Health Habbits

13. In the last 5 years have you or do you plan to:
    a. Be a member of any armed forces or military unit? ☐ Yes ☐ No
    b. Pilot any type of aircraft? ☐ Yes ☐ No
        i. If yes, ☐ Student ☐ Private ☐ Commercial ☐ ATR Total Hours experience _____
        ii. Do you have an Instrument Flight Rating? ☐ Yes ☐ No Any other rating? _____
        iii. Class and date of FAA medical certification held: _____
        iv. Hours flown per year: This year _____ Last Year _____
14. Live outside or travel outside the U.S. or Canada? ☐ Yes ☐ No
15. Engage in scuba/skin diving? ☐ Yes ☐ No
    a. If yes, how many feet ☐ 0-75ft ☐ 76-100ft ☐ 101-150ft ☐ 150+ft Do you dive Alone? ☐ Yes ☐ No
    b. Number of Dives in past 12 months _____ expected in next 12 months _____ Average time _____
    c. Location and description of dives (i.e. cave diving, salvage diving)_____
    d. How many years have you been diving? _____ Other pertinent info _____
16. Have you ever used any form of tobacco or nicotine? ☐ Yes ☐ No
    a. If yes, date last used _____ type _____ Frequency _____

Proposed Insured _____

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Activities/Health Habbits Continued

17. Have you ever had a problem with drug or alcohol abuse? ……☐ Yes ☐ No
    a. If yes, details (including dates, treatment, support groups)_____
18. In the last 5 years have you been convicted of DUI or had two or more moving violations? ……☐ Yes ☐ No

Details for any yes answers: _____

_____

Notice of Information Practices

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request of the insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your life. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures se forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this Noticed or their reinsurers may also release information in their files to other life insurance companies to whom you apply for life or health insurance, or to whom a claim or benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on the information provided by you. The companies may also seek information from others, such as medical professionals who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR WRITTEN REQUEST TO DIVERSIFIED INDIVIDUAL BROKERAGE, 427 NAUBUC AVENUE, SUITE 103, GLASTONBURY, CONNECTICUT 06033

Allianz Life, American Equity, American General , American National , APPS, Assurity Life, AXA Equitable, Aviva Life and Annuity, Banner Life, Centrian Life, Chase Insurance, Clnical Reference Lab (CRL), Columbian Life, Columbian Mutual Life, Columbus Life, Companion Life, Coventry First, CPS Insurance, Diversified Individual Brokerage, EMSI, ExamOne, Express Imaging Services, Equitrust, Fidelity and Guaranty Life, First MetLIfe, Foresters, Genworth, Guaradian, ING Reliastar, Jetstream, John Hancock, Liberty Life, Life of the Southwest, Linocln Financial, Mass Mutual, MetLife, Minnesota Life, Mutual of Omaha, National Life, National Western, Nationwide, New York Life, North American Life & Health, Oxford Life, Pacific Life, Penn Mutual, Portamedic, Presidential, Principal Life, Protective Life, Prudential Finanical, SBLI, Security Mutual, Sentinel, Southland, Standard, Symetra,Transamerica, Union Central, United Home Life, United of Omaha, United States Life, William Penn, Zurich

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Authorization to Release Information

(This authorization complies with HIPAA Privacy Rules)

Name _____

Social Security # _____

I authorize _____ to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It also includes motor vehicle records.

For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical records to the Company, excluding psychotherapy notes.

This Authorization may be revoked at any time by writing us at any of the Service Offices in the Important Notice. The revocation will not be valid to the extent we relied on the Authorization to contest coverage. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.

The Company may retain and disclose information to the Medical Information Bureau, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

Once disclosed to the Company, the information will no longer be protected by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.

This Authorization also applies to any member of my family proposed for coverage in the application and is valid for two years after the date below.

A copy of this Authorization will be provided to me by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.

I have read and agreed to all the applicable terms of this form. I also understand this form in its entirety will be provided to the individual listed in the Authorization above in order to request medical information to determine eligibility for coverage.

Signature of primary proposed insured **X**_____ ____/____/____
Month day year