

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

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? _____

How much life insurance inforce now? _____

Agent Information

Name

Agency

Phone Number

Email Address

Street Address

City

State

Zip Code

Medical History

Height ___ feet ___ inches

Weight _____ pounds

Name, Address Primary Physician

Date Last Consulted

Reason Last Consulted

List current medications & conditions:

Other Pertinent Physicians: (i.e. Cardiologist, OBGYN, Dermatologist, etc.)

Name: _____ Phone _____ Date Last Seen _____ Reason _____

Name: _____ Phone _____ Date Last Seen _____ Reason _____

Medical Tests

Test	Date (Most recent)	Result (If abnormal provide details)
Blood Pressure		
Cholesterol		Total: _____mg Ratio: _____
EKG		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mammogram		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
PSA ^(men) Prostate Specific Antigen		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Details:		

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 which 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 set 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, Clinical 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, Guardian, ING Reliastar, Jetstream, John Hancock, Liberty Life, Life of the Southwest, Lincoln 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 Financial, SBLI, Security Mutual, Sentinel, Southland, Standard, Symetra, Transamerica, Union Central, United Home Life, United of Omaha, United States Life, William Penn, Zurich

Authorization to Release Information

(This authorization complies with HIPAA Privacy Rules)

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 Proposed Insured or Authorized Representative _____
Date

Printed Name of Proposed Insured _____
Social Security # _____
Date of Birth _____
Address of Proposed Insured

Name of Agent

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