

Informal Inquiry

NOT AN APPLICATION FOR LIFE INSURANCE

800-451-2351 Fax 916-965-5418

Date: _____

Affiliate: _____

Applicant: _____ Male: Female: DOB: _____

SS #: _____ U.S. Citizen: YES: NO: Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Occupation: _____ How Long: _____ E-Mail Address: _____

Income: _____ Assets: _____ Liabilities: _____ Net Worth: _____

Life Insurance Currently In Force:

Company	Year Issued	Face Amount	Cash Surrender Value	Are You Looking to Replace	
				YES <input type="checkbox"/>	NO <input type="checkbox"/>
				YES <input type="checkbox"/>	NO <input type="checkbox"/>
				YES <input type="checkbox"/>	NO <input type="checkbox"/>

Do you participate in hazardous activities? Flying Scuba Diving Sky Diving Mountain Climbing Other: _____

Have you ever used any tobacco products? YES NO Has use been discontinued? YES NO Date stopped: _____

What tobacco products did you use? _____ What was the frequency of use? _____

In the last 12 months have you been declined, post-poned or asked to pay extra for life insurance coverage? YES NO

If yes, please, list why you were given this offer: _____

Height: _____ Weight: _____ Do you have a history of any of the following Health issues (check of the ones which apply)?

- Aneurysm—Location _____ COPD (Chronic Obstructive Pulmonary Disease)
- Alzheimer and/or Dementia Has Memory been tested Coronary Artery Bypass Graft (CABG)
- Asthma Coronary Artery Disease (CAD)
- Atrial Fibrulation - Date of Last EKG or Echo _____ Crohn's Disease
- Pace Maker Diabetes
- ICD Emphysema
- Barrett's Esophagus— Secondary Symptom to GERD Hepatitis C
- Bypass Surgery High Blood Pressure (Hypertension)
- Number of vessels effected _____ Kidney or Liver Issues
- Cancer-Last date of treatment _____ Lymphoma
- Breast Mitral Valve Disorder
- Colon Multiple Sclerosis
- Prostate Myocardial Infarction (Heart Attack)
- Skin Parkinson's Disease
- Other Rheumatoid Arthritis
- Claudication—Peripheral Vascular Disease (PVD) Sleep Apnea
- Cardiomyopathy Stroke -TIA or CVA _____
- Ulcerative Colitis

Please explain, with detail, ALL checked boxes from the previous page:

Please list any other health issues you have:

Family History Check here if this section is not applicable

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer YES NO

Relationship	Diagnosis	Approximate age at onset of disease. If deceased, age at death and cause.

Have you had any moving violations in the last 5 years? YES NO

If yes, please provide dates: _____

Who is your Primary Care Physician: _____

Address: _____

Telephone: _____ When did you last consult your doctor? _____

Reason: _____

Other Physician: _____ Reason: _____

Address: _____

Other Physician: _____ Reason: _____

Address: _____

CURRENT MEDICATIONS/SUPPLEMENTS
Prescription & Non-Prescription

Please list **ALL MEDICATIONS** you are currently taking

Name of Medication: _____ Dosage: _____

Purpose: _____

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Purpose: _____

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Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____

Name of Medication: _____ Dosage: _____

Purpose: _____



HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured/Patient (Please type or print)

Date of Birth

First

MI

Last

Month/Day/Year

I authorize any: person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsure, insurance support organization, the Medical Information Bureau, Inc., consumer, reporting agency, state motor vehicle agency, employer, or any other person or institution to release to: each of the insurance companies listed below as well as to their reinsure, any insurance support organizations, and those persons authorized to represent them; and USA Advanced Planning, L.L.C.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputation, finances, occupation, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

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 any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the insurers named below and their reinsurers will use this information to help determine my eligibility for insurance. The insurance agent may also use this information to help update and improve my insurance program.

I agree that the above named parties may also disclose my information to other insurers, reinsurers, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with the underwriting process, or as may be otherwise lawfully required.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to USA Advanced Planning, L.L.C. at:

50 Louis Street, NW
Suite 400
Grand Rapids, MI 49503

I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information but it will not be redisclosed by USA Advanced Planning, L.L.C. except as authorized by me or as required by law.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I understand that My Providers may not refuse to provide treatment or refuse to pay for health care services. 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 carriers listed below may not be able to review my medical file. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of proposed insured

Name of Proposed Insured

Signature of additional proposed insured (if applicable)

Name of Additional Proposed Insured

City

State

Month / Day / Year

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- | | | |
|-------------------------------------|--|------------------------------|
| A1 Credit | ING Companies | Polaris |
| Advanced Planning Services, Inc. | Integrity Life | Portamedic |
| Advanced Settlements | Jackson National | Premium Funding Group |
| AIG (American General) | Jefferson Pilot | Presidential Life |
| Allianz | Legacy Marketing Group | Principal Life |
| American Equity | John Hancock Life Ins. Co. &(NY) | Protective life |
| American Investors | John Hancock USA (ManuLife) & (NY) | Prudential Life Ins. Co. |
| American National | Lafayette Life | RBC |
| Americo Financial Life Ins. Co. | Liberty Life (RBC) | Ridge Capital |
| Assurity Life | Life Insurance Concepts | RSA Medical |
| Amerus/Aviva/Indianapolis Life | Life Insurance Settlements | Security Mutual |
| AXA/MONY | Life of Southwest | Sentinel Funding Group |
| Banner Life | Lincoln Benefit Life | Shenandoah Life |
| Beneficial Financial Group | Lincoln Financial Group | Standard Life |
| CFC of Delaware | Lloyds of London | Sun Life Financial/ Keyport |
| Coventry | Metropolitan Life Ins. Co. | Superior Medical Group |
| Credit Suisse | Minnesota Life | Symetra Financial |
| Conseco | Mutual of Omaha | The Standard |
| ECA Marketing, Inc. | NACOLAH | Transamerica Occidental Life |
| Equitrust | National Life | Union Central |
| First Penn Pacific Life Ins. Co. | National Western | USA Advanced Planning |
| Foresters | Nationwide | US Financial |
| GE Capital | New York Life | US Life (AIG) NY |
| GE Financial Assurance Co. | NIW | Union Central |
| General American Life Insurance Co. | North American Life | United of Omaha |
| GenWorth/First Colony | Old Mutual Financial Network(Americom, | USG |
| Great American Life | F&G) & (NY) | West Coast Life Ins. Co. |
| Guardian Life Insurance Co. | Pacific Life | Western Reserve Life |
| Hartford Life Insurance Co. | Penn Mutual | William Penn of New York |
| | Phoenix | |