8888 Keystone Crossing, Suite 550
Indianapolis, IN 46240
T: 317.569.7080
800.382.4636
F: 317.569.7090

Preliminary Inquiry

This is not an application for life insurance. It is a preliminary evaluation to assist in determining insurability only.

Client Information

Name _____ ❑ Male ❑ Female Social Security # _____/_____/_____
Address _____ City _____ State _____ Zip _____
Home Phone: _____ Occupation: _____ Business Phone: _____
Date of Birth: _____ Age: _____ Place of Birth: _____
Nicotine Use: ❑ None ❑ Cigarettes – frequency of use per day: _____ ❑ Cigars - frequency: _____ ❑ Pipe ❑ Chew
Former Tobacco User: List each type of tobacco, quantity and frequency used and date of last use: _____
Family History: To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60 due to cardiovascular, cerebrovascular disease, diabetes or cancer? ❑ Yes ❑ No
If Yes, provide full details with impairment, age at onset and age at death if deceased: _____
_____
Hazardous Activities: In the past 5 years have you or do you intend to participate in any hazardous activities?
❑ None ❑ Racing ❑Sky Diving ❑ Scuba Diving ❑Mountain Climbing ❑ Private Pilot ❑ Other
Details: _____

Medical Provider Information *(Must Be Completed) - Please be specific with above information & include phone numbers. It will expedite processing.*

List all physicians you have consulted in the past *10 years*	City, State	Phone Number	Date / Reason
1.			
2.			
3.			
4.			

Please list all current medications (including dosage):

Medication	Dosage

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply and provide treatment date.

	Date		*Date*		*Date*
❑ Alcohol or Drug Abuse	_____	❑ Coronary Artery Disease	_____	❑ High Blood Pressure	_____
❑ Alzheimer's/Dementia	_____	❑ Crohn's Disease	_____	❑ Irregular Heartbeat	_____
❑ Cognitive Impairment	_____	❑ Diabetes	_____	❑ Kidney Disease	_____
❑ Cancer	_____	❑ Elevated Cholesterol	_____	❑ Multiple Sclerosis	_____
❑ Cirrhosis	_____	❑ Heart Murmur/Valve Disease	_____	❑ Rheumatoid Arthritis	_____
❑ COPD	_____	❑ Hepatitis	_____	❑ Sleep Apnea	_____
				❑ Stroke	_____

Requested Plan of Insurance

❑ Universal Life ❑ Whole Life ❑ Survivorship ❑ Term
Face Amount Desired: $_____ Premium Amount Desired: $_____ ❑ Annually ❑ Monthly
Purpose of Insurance? _____ Name of Beneficiary _____ Relationship _____

Travel

Have you traveled in the past 5 years OR do you intend to travel outside the United States in the next 5 years? ❑ Yes ❑ No
If *YES*, where did you travel in the past 5 years, when and for how long OR where do you intend to travel, when, and for how long?

Authorization for Release of Health-Related Information and Personal Psychotherapy Notes

This authorization complies with the HIPAA Privacy Rule

Proposed Insured: _____ Date of Birth _____ SS# _____/_____/_____

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 personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). 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, tobacco, and psychotherapy notes. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

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

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

This authorization shall remain in force for 24 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 to The Companies, to the attention Privacy Official. 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 Companies have 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 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 Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The Companies:

Advanced Settlements	2101 Park Center Dr, Ste 220 Orlando, FL, 32835	*Met Life*	One City Place 185 Asylum, 7th Fl, Hartford, CT 06103
Accordia Life	PO Box 305027, Nashville, TN 37230-5027	*Minnesota Life*	PO Box 64299, St Paul, MN 55164-0299
AIG Life Insurance Co.	600 King St., Wilmington, DE 19801	*MONY Life Insurance Co.*	175 Powder Forest Dr., PO Box 2001, Simsbury, CT 06070-7681
American General Insurance	American General Center – MC 338N, Nashville, TN 37250	*Mutual of Omaha*	Mutual of Omaha Plaze, Omaha, NE 68175
American National	1 Moody Plaza, Galveston, TX 77550	*New York Life Insurance Co.*	51 Madison Ave, Suite 3200, New York, NY 10010
Allianz Life Insurance Co.	PO Box 1344, Minneapolis, MN 55440-1344	*Nationwide Life*	One Nationwide Plaza, Columbus, OH 43215
AVIVA	699 Walnut St. H75, Des Moines, IA 50309	*Pacific Life Insurance Co.*	700 Newport Center Dr., Newport Beach, CA 92660
AXA – Equitable Life	PO Box 6040 Lynchburg, VA 24505	*The Phoenix Companies, Inc.*	30 Dan Rd., Canton, MA 02021
Banner Life	1701 Research Blvd., Suite 300, Minneapolis, MN 55433	*Protective Life Insurance Co.*	2-3 UN Brokerage Life Services, 2801 Highway 280 S., Birmingham, AL 35223
Capitas Financial, Inc. (Rushing Financial Group)	8888 Keystone Crossing, Suite 550, Indianapolis, IN 46240	*Principal Life Insurance Co. – Principal National Life*	801 Grand Ave., Des Moines, IA 50392
Genworth	700 Main St., Lynchburg, V A 24505	*Prudential Select Brokerage*	13001 County Rd 10, 4th Fl., Plymouth, MN 55442
ING Companies	5780 Powers Ferry Rd NW, Atlanta, GA 30327-4390	*Symetra Life Insurance Co.*	777 108th Ave NE, Suite 1200, Bellevue, WA 98004
John Hancock Life Insurance	200 Clarendon St. C-8, Boston, MA 02117	*Transamerica Life Ins. Co. – Transamerica Financial Life Ins. Co*	4333 Edgewood Rd NE, Cedar Rapids, IA 52499
Lincoln Benefit	PO Box 80469, Lincoln, NE 68501	*West Coast Life*	20000 Victor Parkway, Suite 110, Livonia, MI 48152
Lincoln Financial Group	350 Church St., Hartford, CT 06103-1106	*Zurich American Life Ins. Co.*	7045 College Blvd., Overland Park, KS 66211-1523

The terms that follow have the respective meanings when used in this Authorization:

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

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

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

If for a Lifetime Settlement, I understand that settlement providers and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner, or which I am the insured, and I hereby expressly authorize such use and disclosure

_____ _____

Proposed Insured / Patient / Authorized Personal Representative (Signature) *Date*

Notes:

Use this section to list additional physicians you have consulted or additional medications you take.