preliminary inquiry

confidential - this is not an application for insurance

PERSONAL INFORMATION

Name: _____ ☐ Male ☐ Female Social Security No. _____

Address _____ City _____ State _____ Zipcode _____

Date of Birth _____ Citizenship _____ Age _____ Height _____ Weight _____

Occupation _____ What are your duties? _____

Annual Earned Income $ _____ Annual Unearned Income $ _____ Net Worth $ _____ Phone _____

Do you currently use tobacco products? ☐ Yes ☐ No Details _____

Type of tobacco used: ☐ Cigarettes ☐ Cigars ☐ Chewing Tobacco ☐ Pipe Other _____

Does your driving history contain any moving violations or license suspensions ☐ Yes ☐ No

If "yes", details _____

Avocation Activities ☐ Private Pilot? ☐ Sky Dive? ☐ Mountain Climb? ☐ Foreign Travel? If "Yes" Country _____

☐ Scuba Dive? ☐ Hang Glide? ☐ Auto/Motorcycle Race?

Details _____

Family Health History	Age if living	Age at death (if deceased)	History of heart disease, stroke circulatory disorder, kidney disease?	History of cancer (all types)?
Mother	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Father	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Brother(s)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No
Sister(s)	_____	_____	☐ Yes ☐ No	☐ Yes ☐ No

Have you ever sold a policy as a "Life Settlement" in the secondary market? ☐ Yes ☐ No

Have you ever been declined for coverage or been rated? ☐ Yes ☐ No If yes, please complete the following:

Company _____ Coverage Amount $ _____ Issue Date _____ Rating _____ Plan Type _____ Surrender Value $ _____

PLAN OF INSURANCE

☐ Term ☐ Whole Life ☐ Universal Life ☐ Indexed UL ☐ Variable UL

☐ Individual ☐ Survivorship Face Amount $ _____ Premium $ _____

Owner _____ Beneficiary _____ Relationship _____

Is this case currently being shopped through another Brokerage General Agency? ☐ Yes ☐ No

Is this case currently being reviewed by an insurance carrier? ☐ Yes ☐ No If "yes", which carrier(s)? _____

What offers, ratings, or declinations have you received on this case? (Please list offers and carriers):

_____

IN FORCE INSURANCE

Total amount in force $ _____ Pending insurance? ☐ Yes ☐ No Date of last application? _____

Company(ies) _____

Is existing coverage being replaced? ☐ Yes ☐ No If "yes", total coverage being replaced? $ _____

Company(ies) _____

AGENT INFORMATION

Name: _____ Firm _____ Phone _____ Fax _____ Email _____

Advisor's Choice
INSURANCE BROKERAGE SERVICES

please print and fax to: 805-246-9231 or e-mail to: salessupport@myadvisorschoice.com
250 N. Westlake Blvd., Ste. 240 Westlake Village, CA 91362 | toll free: 855-437-1090

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MEDICAL HISTORY - THIS INFORMATION MUST BE COMPLETED WITH ALL KNOWN INFORMATION

Please list ALL physicians you have consulted or seen over the past 5 years, including any specialists (attach additional pages if necessary)

Primary physician's name _____ Date(s) seen _____

Reason(s) seen _____

Physician's street address _____ City _____ State _____ Phone _____

Personal physician's name _____ Date(s) seen _____

Reason(s) seen _____

Physician's street address _____ City _____ State _____ Phone _____

Personal physician's name _____ Date(s) seen _____

Reason(s) seen _____

Physician's street address _____ City _____ State _____ Phone _____

Please indicate any hospitals or clinics where you have received treatment (attach additional pages if necessary)

Hospital or clinic name _____ Date(s) of visit _____

Reason(s) of visit _____

Hospital/Clinic's street address _____ City _____ State _____ Phone _____

Please list all current medications _____

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:

Chest pain, shortness of breath, heart murmur, blood pressure, stroke, irregular heartbeat, or any other disease of the heart or arteries?	☐ Yes	☐ No
Diabetes or disease of the glands?	☐ Yes	☐ No
Mental, emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?	☐ Yes	☐ No
Arthritis, gout, or any bone, joint, muscle, or skin disorder?	☐ Yes	☐ No
Asthma, bronchitis, pneumonia, emphysema, or any lung disorder?	☐ Yes	☐ No
Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gallbladder, pancreas, stomach, or intestines?	☐ Yes	☐ No
Prostate or testicular disease, disease of the uterus, ovaries, or breast?	☐ Yes	☐ No
Anemia, leukemia, clotting disorders, or platelet disorders?	☐ Yes	☐ No
Disorder of the urinary tract or kidneys - sugar, albumin, or blood in the urine?	☐ Yes	☐ No
Cancer or tumors?	☐ Yes	☐ No
An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance)?	☐ Yes	☐ No
Any other health impairment or medically treated condition not previously mentioned?	☐ Yes	☐ No
Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes	☐ No

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS TO THE ABOVE QUESTIONS in the space below. Attach additional pages if necessary. Please be specific with this information and include phone numbers:

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addendum to preliminary inquiry

confidential - this is not an application for insurance and must accompany the signed preliminary inquiry and HIPPA authorization

Prescription/Supplement Questionnaire

Date: _____

Client Name: _____

Advisor Name: _____

Please complete the below for all medications and supplements for which the client is currently taking:

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Medication_____
Dosage_____/mg Frequency (# times/day): _____
Purpose_____ Prescribing Physician_____

Supplement_____
Dosage_____ Purpose_____

Supplement_____
Dosage_____ Purpose_____

Supplement_____
Dosage_____ Purpose_____

please print and fax to: 805-246-9233 or e-mail to: casemanagement@myadvisorschoice.com
250 N. Westlake Blvd., Ste. 240 Westlake Village, CA 91362 | toll free: 855-437-1090

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number

This form is HIPAA compliant

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance companies or the insurance agencies listed below, contractors, employees, representatives and agents working through Advisor's Choice Insurance Brokerage Services, LLC for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies

Advantage Insurance Network	Examination Management Services, Inc.	John Hancock USA	Premium Funding Group (PFG)
Advisor's Choice Insurance Brokerage Services, LLC	Express Imaging Services	Kestler Financial	Principal Life
Agent's Preferred Insurance Services, LLC	Fidelity & Guaranty Life Insurance Company	Lafayette Life	Principal National Life
Allianz	Fidelity Security	Life Insurance of the Southwest	Professional Underwriting Services
American National	Foresters	Life Secure	Protective Life Insurance Company
Americo	GE Financial Services	Lincoln Financial/Lincoln Life	Protective Life of NY
Ameritas	Genworth Life & Annuity	Lincoln National Life Insurance Company	Prudential Life Insurance Company/Pruco Life
American General Life (AIG)	Genworth Life Insurance Company	Lloyds of London	SBLI
APPS	Genworth Life of NY	Massachusetts Mutual	Security Mutual
Ashar, LLC	Global Insurance Underwriters	Med America	Standard Life
Assurity Life	Great American	Metlife Investors USA Insurance Company	State Life
Athene	Guardian Life Insurance Company	Metropolitan Life	Sun Life Insurance Company of America
AVIVA/Indianapolis Life	Hartford Life Insurance Company	Minnesota Life/Securian	Sun Life Insurance Company of Canada
AXA/MONY/AXA Equitable	IEP Insurance Brokerage Services, LLC	Mutual of Omaha	Superior Medical Group
Banner Life	I-Group Insurance	National Life of Vermont	Symetra
Calton & Associates, Inc.	Illinois Mutual	Nationwide Life & Annuity Company	Transamerica Life Insurance Company
Cavalier & Associates	ING - ReliaStar	New York Life Insurance Company	Union Central Life
Columbus Life	ING ReliStar Life of New York	Pacific Life	United of Omaha
Companion Life	ING - Security Connecticut Life	Partners Advantage	US Life, NY
Companion Life of NY	ING - Security Life of Denver	Petersen International	Western Reserve Life
Concord Capital/INSCAP Coventry	JH NY	Phoenix Life	William Penn Life Insurance Company
Disability Insurance Services	John Hancock Life Insurance Company	Portamedics	Zurich American Life Insurance Company
Fidelity Life	LTCi Partners	North American for L&H	Penn Mutual

Additional Insurers and Agencies: _____ Insureds Initials _____

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the Proposed Insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____,

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to Advisor's Choice Insurance Brokerage Services, LLC the Insurers and Agencies listed afore and to:

Agent/Producer Name:_____.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X_____ Printed Name: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSUREDS

Instructions to the Agent/Producer: This notice must be given to the Proposed Insured before or at the time of signature

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning 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 would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, 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 the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, 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 NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES. EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.