INFORMAL INQUIRY

PH. (305) 270-0999 * FAX (305) 270-0093

Our full service brokerage organization is committed to comprehensive insurance analysis for your clients. Our on-site underwriting staff can assist you to tentatively rate your clients so you can start with the best potential formal application first!

INSTRUCTIONS

Please complete this form as thoroughly and accurately as possible, including onset dates, prescription names, dosages, and physician's contact information (if requested). Complete, precise information produces the most accurate carrier offers. Because of the significant expense involved in purchasing medical records, our staff has final discretion regarding pre-purchase of client's medical records.

BROKER INFORMATION

Name ____ Firm/Agency _______________________________________

Phone ______________________________ Fax _________________________ Email ________________________________

CASE DESIGN INFORMATION

Circle One: Universal Life Indexed Universal Life Whole Life Term (Period_______)

Death Benefit Amount _____________________________ If no-lapse, carry guarantees to age___________ Option__________

Riders ____ Lump Sum / 1035 Exchange Amount __________________________

Purpose of Coverage (i.e. Estate Planning, Buy-sell, etc.) ____

PROPOSED INSURED INFORMATION

Name ____ Sex ____________ Date of Birth ___________________

Social Security Number _______________________ Drivers License No. __________________________ State of Issue _______

Tobacco Usage (Y/N)_____________Type and amount per day ________________________ Date since last use ____________

FOREIGN TRAVEL / CITIZENSHIP

Country of Residence _________________Country of Citizenship _____________________ Dual Citizenship _________________

Green card (Y/N) _______ Visa Type ____________________ Date of Issue ______________ Date of Expiration ______________

Do you own US property? ________________________ Since when? _________________ US Bank Account (Y/N) ____________

Business Interests (describe) ____ Immediate Family in US (Y/N) __________

Details of foreign travel (include countries and time spent per year) ____

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INSURANCE HISTORY

Have you ever been rated substandard, declined or postponed when applying for Life, LTC, or Disability Insurance? Please include reason, dates, carriers ____

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Pending Insurance Applications (include carrier, amount, outcome) ____

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LIFESTYLE & AVOCATION INFORMATION

1.) Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years? (Y/N) ______ If yes, hours flown last year _______ Anticipated hours next 12 months ______ IFR (Y/N) _________

Date of last flight _____________ License Type _______________ Aircraft type and purpose _________________________________

2.) Have you engaged or do you plan to engage in scuba or skin diving? (Y/N) ______ If yes, number of dives last year _______

Anticipated dives next 12 months ________ Certification Type _____________________________ Maximum Depth ______________

Where do you dive? (i.e. rivers, ocean, lake) _______________________ Purpose (recreational/commercial) ___________________

3.) Have you engaged in or do you plan to engage in any other hazardous sports or activities? (Y/N)_________ If yes, provide complete details ____

4.) Have you declared bankruptcy? (Y/N) ______ If yes, what Chapter? ______ Date filed_________ Date Dismissed_________

5.) Have you ever been convicted of misdemeanor or felony offense in the last 10 years? (Y/N) ________ If yes, provide complete details ____

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6.) Do you consume recreational drugs? (Y/N) _________ If yes, provide specific type used ________________________________

Quantity used? ________________ Frequency? ________________ Date last used ________________

Have you ever been treated for, or recommended to seek treatment for drug or alcohol abuse? (provide details) ________________

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7.) In the past 5 years, have you had any moving violations or been cited for driving while impaired?(Y/N) ___________ If yes, please provide details and dates of occurrences ____

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MEDICAL INFORMATION

Height _________________ Weight __________________ Any change greater than 10 pounds in last year? __________ If yes, please explain? ____

Medications (include date started and dosage) Please list prescription and non-prescription medications ______________________

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MEDICAL QUESTIONS

Have you ever had or have symptoms of, or been told by a physician that you have had or have any of the following :

1.) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke (TIA), irregular heartbeat, or any other disease or disorder of the heart or arteries?
2.) Diabetes, elevated blood sugar or glucose intolerance, thyroid, or other endocrine or glandular disease?
3.) Any tumor, cancer, cyst, melanoma, lymphoma, or any disease of the lymph nodes?
4.) Arthritis, gout, or any disease of the back, spine, muscles, nerves, bones, joints, or skin?
5.) Anemia, leukemia, clotting disease or any other blood disease?
6.) Asthma, emphysema, allergies, sleep apnea, tuberculosis, sarcoidosis, persistent hoarseness or shortness of breath or any other disease of the respiratory system?
7.) Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disease of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?
8.) Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurological or brain disease?
9.) Any nervous, mental, or emotional disease, or received counseling for anxiety, depression, stress or any other emotional disease?
10.) Any complications of pregnancy or disease of the testicles, prostate, breast, ovaries, uterus, cervix, kidney, or bladder?
11.) Any disease of the eyes, ears, nose or throat?
12.) Any mental or physical diagnosis or medically or surgically treated condition not listed above?

Please provide details including question number, diagnosis, date of onset, duration of condition, treatments, current status and name & telephone number of physician/specialist that treated or is treating condition.

Details

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EMMETT
INSURANCE GROUP

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Details continued

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA ACT AND PRIVACY RULES

Patient Name ____

Date of Birth ______________________________________ Social Security Number ______________________________________

This authorization is for Release of Health-Related Information to the following:

Name ____

Address ____ City ________________________ State _________ Zip _____________

My Providers are any health plan physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or service to me or on my behalf. This includes psychotherapy care. My Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of the Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; the use of alcohol, drugs, and tobacco; and psychotherapy notes.

I authorize My Providers to disclose my Protected Health Information to the above named company or person(s); their agents, employees, and representatives.

By signing below: 1.) I acknowledge that any agreements I make that restrict my Protected Health Information do not apply to this authorization; and 2.) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the above named 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 provide coverage and benefits; 4.) administer coverage; and 5.) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the above named. This authorization shall remain in-force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by doing so in writing and presenting the written revocation to the above named. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to an insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that My Providers may not refuse to provide treatment of 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 protected Health Information, the above named may not be able to assist me in processing my application. I acknowledge that I have received a copy of this Authorization.

Patient or personal representative signature ____ Date __________________

Authorized Insurance Carriers and Underwriting Information Vendors

Portamedic and Equifax Services, Allianz, American General Life Insurance Company/US Life Insurance Company, American National Life Insurance Company, Accordia Life, AXA Advisors/Equitable/MONY Life Insurance Companies, LG America, GE Financial/Genworth Companies, Genworth Life Insurance Company, Genworth Life and Annuity Insurance Company, John Hancock, John Hancock USA, Lincoln National Life, MetLife Investors/Metropolitan Life Insurance Companies, Nationwide Financial, North American Company for Life and Health Insurance, Pacific Life, Principal Financial Group, roProtective Life/Protective Life and Annuity Companies, Prudential Life, Savings Bank Life of MA, Symetra Life Insurance Company, The Standard Insurance Company, Transamerica Life Companies, United Home Life, United of Omaha/Mutual of Omaha Life Companies, Voya Financial, and Zurich American