

PERSONAL HISTORY			
Name _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Social Security # _____
Address _____	City _____	State _____	Zip _____
Home Phone: _____	Business Phone: _____		
Date of Birth _____	Age _____	Height _____	Weight _____ Monthly Earned Income _____
Occupation _____		What are your duties? _____	
When last used tobacco? Cigarettes _____	Cigars _____	Other _____	
Hazardous Activities: Private Pilot: <input type="checkbox"/> Yes <input type="checkbox"/> No		Scuba Diving: <input type="checkbox"/> Yes <input type="checkbox"/> No	Sky Diving: <input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL HISTORY – THIS SECTION MUST BE FULLY COMPLETED			
1. Who is your personal physician?	Doctor's name, address and phone number	When did you last consult him/her?	
		Date	Illness
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations)			
3. In what clinics, hospitals, or sanitariums have you ever been treated?			
4. Please list all current medications:			

Please be specific with above information & include phone numbers. It will expedite processing.

	Yes	No
A Epilepsy, fainting spells, nervous or mental condition, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?	_____	_____
B Heart attack, murmur, palpitation, or high blood pressure, anemia, varicose veins, or any disease or abnormality of the heart, blood, or blood vessels?	_____	_____
C Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?	_____	_____
D Ulcer, indigestion, colitis, gall stones, hernia, or any disease or abnormality of the stomach, intestines, rectum, gall bladder, or liver?	_____	_____
E Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate, urinary or genital systems?	_____	_____
F Diabetes, gout, or any disease or abnormality of the thyroid or other glands?	_____	_____
G Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?	_____	_____
H Any disease or abnormality of the eyes, ears, or skin?	_____	_____
I Cancer or tumor?	_____	_____
J Any physical deformity or defect?	_____	_____
K An immune deficiency disorder, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection?	_____	_____

TRAVEL

1. Have you traveled in the past 5 yrs OR do you intend to travel outside the United States in the next 5 yrs? Yes ___ No ___

2. If YES, where did you travel in the past 5 yrs, when and for how long OR where do you intend to travel, when, and for how long?

Within the past ten years, has any person to be covered used:

Yes No

A Amphetamines, barbiturates, sedatives, or morphine or any other narcotic drug except as prescribed by a physician?

B Cocaine, heroin, marijuana, PCP, LSD, or any other hallucinogenic drug?

A Have any close relative of any person to be covered ever had cancer, diabetes, heart disease, or a nervous or mental abnormality?

B Has any person to be covered ever received treatment or joined an organization for alcoholism or drug addiction?

C Is any person to be covered now pregnant?

REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED

<input type="checkbox"/> Universal Life	<input type="checkbox"/> Whole Life	<input type="checkbox"/> Term	<input type="checkbox"/> Survivorship
Face amount desired \$ _____	Premium Amount desired \$ _____	<input type="checkbox"/> Annually	<input type="checkbox"/> Monthly
What will be the purpose of the insurance?	Name of beneficiary	Relationship	

WHAT ADVERSE ACTION OR TABLE RATING WAS OFFERED BY ANOTHER COMPANY?

Did your primary company work this case? Yes No


Company	Date	Amount	Action	Current Premium	Total

Is this case being considered by another Impaired Risk Agency? Yes No

OTHER INSURANCE ON PROPOSED INSURED

Total amount in force _____ Date of last application _____ Is this insurance applied for to replace insurance? Yes No
Name of Company _____ Of so, premium being replaced _____

AGENT INFORMATION

Name _____	Firm Name _____	SS# _____	
Address _____	City _____	State _____	Zip _____

HAVE ATTACHED AUTHORIZATIONS SIGNED SO THAT MEDICAL RECORDS CAN BE OBTAINED

Send your completed documents to:

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: _____

THE COMPANIES:	
AIG Life Insurance Company	600 King Street, Wilmington, DE 19801
Advanced Settlements, Inc.	2101 Park Center Drive, Suite 200, Orlando, FL 32835
American General Insurance	American General Center - MC 338N, Nashville, TN 37250
AXA	
Capitas Financial of Illinois, LLC	3025 Highland Parkway, Suite 185 Downers Grove, IL 60515
Banner Life	1701 Research BLVD, Rockville, Maryland 20850
Coventry First, LLC	7111 Valley Green Road, Fort Washington, PA 19034
Empire General Life Assurance Co.	2801 Highway 280 South, Birmingham, AL 35223
First Penn Pacific	10 N. Martingale Road, Schaumburg, IL 60173
Genworth	700 Main Street, Lynchburg, VA 24505
Indianapolis Life	699 Walnut Street H75, Des Moines, IA 50309
John Hancock Life Insurance	200 Clarendon Street C-8, Boston, MA 02117
Jefferson Pilot	100 N. Green Street, Greensboro, NC 27401
Lincoln Benefit	PO Box 80469, Lincoln, NE 68501
Lincoln Financial Group	350 Church Street, Hartford, CT 06103-1106
ING Companies	5780 Powers Ferry Road NW, Atlanta, GA 30327-4390
Maple Life Financial	7316 Wisconsin Ave, Ste 500, Bethesda, MD 20814-2937
Met Life	One City Place 185 Asylum, 7 th Floor, Hartford CT 06103
MONY Life Insurance Company	175 Powder Forest Drive, P.O. Box 2001, Simsbury, CT 06070-7681
New York Life Insurance Company	51 Madison Avenue, Suite 3200, New York, NY 10010
Nationwide Life	One Nationwide Plaza, Columbus, OH 43215-2220
Pacific Life Insurance Co.	700 Newport Center Drive, Newport Beach, CA 92660
Principal Life Insurance Co	801 Grand Ave; Des Moines, IA 50392
Protective Life Insurance Co.	2-3 UN Brokerage Life Services, 2801 Highway 280 South, Birmingham, AL 35223
Prudential Select Brokerage	Attn: Underwriting, 13001 County Road 10, 4th Floor, Plymouth, MN 55442
ReliaStar Life Insurance Co.	5780 Powers Ferry Road NW, Atlanta, GA 30327-4390
ReliaStar Life Insurance Co. of NY	5780 Powers Ferry Road NW, Atlanta, GA 30327-4390
Security Connecticut	5780 Powers Ferry Road NW, Atlanta, GA 30327-4390
Southland Life	5780 Powers Ferry Road NW, Atlanta, GA 30327-4390
State Life Insurance Company	One American Square, Suite #715A, Indianapolis, IN 46282
Sun Life Assurance Co. of Canada	One Sun Life Executive Park, Wellesley Hills, MA 02481-0002
Transamerica Occidental Life Ins. Co.	4333 Edwood Road NE, Cedar Rapids, IA 52499
West Coast Life	20000 Victor Parkway, Suite #110, Livonia, MI 48152

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

Signed at _____	this _____	day of _____	20____
_____	_____	_____	_____
Proposed Insured Signature	Proposed Owner's Signature		

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

Name of Minor Child	Signature of Minor Child's Authorized Representative
Name of Minor Child's Authorized Representative	Witness (Broker)

Authorization for Release of Health-Related Information - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization

Date of Birth

_____	_____
_____	_____
_____	_____

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, and tobacco, but excludes 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 conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

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.

Signature of Proposed Insured, Patient, or Personal Representative

Date

x

Signature of Proposed Insured, Patient, or Personal Representative

Date

x

Signature of Proposed Insured, Patient, or Personal Representative

Date

x

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Personal Psychotherapy Notes - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization

Date of Birth

_____	_____
_____	_____
_____	_____

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 solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). 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 conversation 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 as described above 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 as described above, 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.

Signature of Proposed Insured, Patient, or Personal Representative x	Date
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Signature of Proposed Insured, Patient, or Personal Representative x	Date
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Signature of Proposed Insured, Patient, or Personal Representative x	Date
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Description of Personal Representative's Authority or Relationship to Patient
