Personal Information Page

Please complete this form in its entirety. Missing information may delay the establishment of your policy.

Personal Information

Name: Sex: Male / Female

Date of Birth: Social Security #

Birthplace: Citizenship:

Home Address:

Home Phone: Work Phone:

Cell Phone: Email:

Driver's License # Driver's License State:

DL Issue Date: DL Expiration Date:

Annual Earned Income: Unearned Income Net Worth:

Liquid Assets (ESTIMATED):

Occupation: Name of Employer:

Employer Address:

Personal History Questions

1. Do you anticipate any foreign travel within the next 2 years? ☐ Yes ☐ No
2. Within the last 3 years have you been, or within the next 2 years do you expect to become a pilot? ☐ Yes ☐ No
3. Within the last 3 years have you taken part in, or within the next 2 years expect to take part in any hazardous activities or extreme sports (diving, hang gliding, para sailing, skydiving…)? ☐ Yes ☐ No
4. Within the last 5 years, have you been in a motor vehicle accident or convicted of a moving violation? ☐ Yes ☐ No
5. Within the last 10 years, have you been convicted of operating a motor vehicle while under the influence of alcohol or drugs? ☐ Yes ☐ No
6. Have you ever been convicted of a felony, or currently on parole or probation? ☐ Yes ☐ No

If you answered yes to any of the questions above, please provide explanation below.

_____

_____

Account Information

Primary Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Primary Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

In Force Life Insurance: IF NONE, LEAVE BLANK

Date Issued: Carrier: Type:

Insured: Face Amount: Policy #

Spouse:

Siblings (If Juvenile Insured):

Additional Requirements for Disability Insurance:
IF NOT APPLYING FOR DIABILITY INSURANCE PLEASE LEAVE BLANK

Employer Paid Benefits

Plan Design:

Benefit Amount: Benefit Period:

Elimination Period: Other Individual Coverage:

Number of Employees: Owner:

MEDICAL INFORMATION

Please include the name, address, and telephone number of each physician listed.

Personal Primary Care Physician: **Name:** **Address:**	**Telephone Number:**	**Date of Last Visit:**	**Reason for Visit:**
Specialist: **Name:** **Address:**	**Telephone Number:**	**Date of Last Visit:**	**Reason for Visit:**
Specialist: **Name:** **Address:**	**Telephone Number:**	**Date of Last Visit:**	**Reason for Visit:**
Specialist: **Name:** **Address:**	**Telephone Number:**	**Date of Last Visit:**	**Reason for Visit:**
List any Clinics or Hospitals **Name:** **Address:**	**Telephone Number:**	**Date of Admission:**	**Reason for Admission:**

List all current medications:_____

_____

_____

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 agencies listed below, LIFE Brokerage, LLC, brokers, contractors, employees, representatives and agents working through LIFE Brokerage, LLC for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies

Advantage Insurance Network, Inc.	Fidelity & Guaranty Life Ins Co	Lincoln National Life Insurance Co	Prudential Life Ins. Co. / Pruco Life
Allianz	First Global Financial & Insurance	Lloyd's of London	RSA Medical
American General Life (AIG) American	First Insurance Funding	Massachusetts Mutual	SBLI
National	First Penn	Minnesota Life / Securian	Security Mutual
Americo	Foresters	Mutual of Omaha	Standard Life
Assurity Life	General American Life Ins. Co.	National Life of Vermont	Sun Life Ins. Co. of America
Accordia/Global Atlantic	Global Insurance Underwriters	National Western	Sun Life Ins. Co. of Canada
Ameritas	GE Financial Assurance Co.	Nationwide Life & Annuity Co.	Superior Medical Group
Ashar	Genworth Life Insurance Co.	New Investor World, Inc.	Symetra
AVS, LLC	Genworth Life and Annuity	New York Life Insurance Co.	Transamerica Life Insurance Co.
AUS Underwriting	Guardian Life Ins. Co.	North American Co.	Travelers Life & Annuity
AXA / MONY / AXA Equitable	Hartford Life Insurance Co.	Old Mutual Financial Network	21st Services
Banner Life	Industrial Alliance Pacific	One America	Union Central Life
Beneficial Financial Group	IBU, Inc.	Pacific Life	United of Omaha
Bragg Associates	ISC Services	Penn Mutual	USG Annuity & Life
Brighthouse Financial	John Hancock Life Ins. Co.	Petersen International Underwriters	Voya - ReliaStar Life of New York
LIFE Brokerage, LLC	John Hancock USA	Premium Funding Group (PFG)	Voya – ReliaStar Life Insurance Company
Columbus Life	Kestler Financial	Pioneer Mutual	Voya – Security Connecticut Life
Concord Capital/INSCAP	Lafayette Life	Phoenix Life	Voya - Security Life of Denver
Coventry First, LLC	Lewis and Ellis, Inc.	Presidential Life	West Coast Life Insurance Co.
Equity Key, LLC	Life Insurance of the Southwest	Principal Life Insurance Company	Western Reserve Life
Equity Release	LifeShare	Principal National Life Insurance Company	William Penn Life Ins. Co.
Examination Management Services, Inc.	Lincoln Benefit Life	Professional Underwriting Services	Zurich American Life Insurance Company
Fasano Associates, Inc.	Lincoln Financial/ Lincoln Life	Protective Life Ins Co.	

Additional Insurers and Agencies:

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 LIFE Brokerage, 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: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

Medical Questions to Determine Best Carrier Recommendation

PI1

1. Height (in shoes) _____ ft. _____ in.
2. Weight (clothed) _____ lbs.
Weight change in last year? ☐ Yes ☐ No
If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

PI2

3. Height (in shoes) _____ ft. _____ in.
4. Weight (clothed) _____ lbs.
Weight change in last year? ☐ Yes ☐ No
If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

	PI1		PI2	
5. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter?	☐ Yes	☐ No	☐ Yes	☐ No
6. During the past 10 years, has a licensed member of the medical profession treated you for, or made a diagnosis of:				
a. High blood pressure, chest discomfort, heart attack, heart murmur, circulatory or heart disorder?	☐ Yes	☐ No	☐ Yes	☐ No
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?	☐ Yes	☐ No	☐ Yes	☐ No
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?	☐ Yes	☐ No	☐ Yes	☐ No
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?	☐ Yes	☐ No	☐ Yes	☐ No
e. Anemia, leukemia or other blood or clotting disorder?	☐ Yes	☐ No	☐ Yes	☐ No
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?	☐ Yes	☐ No	☐ Yes	☐ No
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?	☐ Yes	☐ No	☐ Yes	☐ No
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?	☐ Yes	☐ No	☐ Yes	☐ No
i. Cancer, tumor, polyp or cyst?	☐ Yes	☐ No	☐ Yes	☐ No
j. Disorder of eyes, ears, nose or throat?	☐ Yes	☐ No	☐ Yes	☐ No
k. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?	☐ Yes	☐ No	☐ Yes	☐ No
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system or a positive blood test for antibodies to the HIV virus?	☐ Yes	☐ No	☐ Yes	☐ No
7. Have you ever used any controlled substances such as: amphetamines, barbiturates, hallucinogens, heroin, morphine, cocaine, marijuana, opiates or any prescription drug, except as prescribed by a physician? If Yes, please complete Substance Use Questionnaire PM0293.	☐ Yes	☐ No	☐ Yes	☐ No
8. Have you ever been advised by a physician to limit or discontinue the use of alcohol or drugs, sought or received medical treatment, counseling or participated in a self help group for alcohol or drug use? If Yes, please complete Substance Use Questionnaire PM0293.	☐ Yes	☐ No	☐ Yes	☐ No
9. Other than previously stated, have you within the past 5 years:				
a. Consulted a physician or any other practitioner, had a check-up, illness, surgery or been hospitalized?	☐ Yes	☐ No	☐ Yes	☐ No
b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test, excluding HIV related tests?	☐ Yes	☐ No	☐ Yes	☐ No
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed, excluding HIV related tests?	☐ Yes	☐ No	☐ Yes	☐ No

Medical Questions (continued)

10. Family History

Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed or treated by a member of the medical profession as having diabetes, heart disease, TIA (transient ischemic attack) or other cerebrovascular disorder, cancer, stroke, Huntington's disease and Chorea, neuromuscular disorder, or kidney disease prior to age 60?

PI 1 ☐ Yes ☐ No PI 2 ☐ Yes ☐ No (If Yes, provide details in Medical Impairment section below.)

	Age(s) (if living)	Age(s) (at death)	Medical Impairment	Cause of Death	Amount of Insurance (Complete if Proposed Insured is under 17)
Father (PI 1)					
Father (PI 2)					
Mother (PI 1)					
Mother (PI 2)					
Brother (PI 1)					
Brother (PI 2)					
Sister (PI 1)					
Sister (PI 2)					

X. Details for Medical History Questions

Question No. and Letter	Person	Date (mm/dd/yyyy)	Details (include full names and address of physicians, hospitals, etc.)