

INFORMAL INQUIRY FORM

1

PRIMARY INSURED INFORMATION

Primary Insured Name _____ Social Security Number _____

Current Address _____

Telephone Number _____ Date of Birth _____

Cell Phone Number _____ Email _____

Driver's License # / State _____ Birthplace _____

➤ Best time & way to reach you: _____

Marital Status: Single Married Divorced Widowed

Gender: Male Female

Dependent Children: Yes No

If yes, List Names: _____

How much life insurance coverage are you interested in (face amount)? \$ _____

Have you claimed bankruptcy: Yes No

Do you have a residence(s) in another state? Yes No

If yes, please provide state(s): _____

Do you have a current will? Yes No

Do you have current estate plan? Yes No

Do you have a life insurance trust(s) established? Yes No

If yes, please provide trust situs / state(s): _____

Does the Primary Insured have existing:

1. Annuity Contracts? Yes No

2. Life Insurance? Yes No

a. If Yes, will life insurance being considered replace existing contracts / policies?

b. Amount of life insurance in force / applied for? \$ _____

3. Long Term Care Policies? Yes No

a. If yes, will life insurance being considered replace or change existing contracts or policies? Yes No

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POLICY OWNER INFORMATION (i.e. Trust, Business or Entity)

Owner Name / Trust Name _____ Tax ID (Trust) _____

Current Address _____

Telephone Number _____ Date of Issue / Date of Incorporation _____

TRUSTEE #1

Name of Trustee #1		
Trustee's Home Address		
Telephone	Fax	Email

TRUSTEE #2

Name of Trustee #1		
Trustee's Home Address		
Telephone	Fax	Email

❖ **ATTORNEY INFORMATION**

Name of Attorney / Attorney Firm		
Attorney's Address		
Telephone	Fax	Email

❖ **CPA INFORMATION**

Name of CPA		
CPA's Address		
Telephone	Fax	Email

3 PRIMARY INSURED MEDICAL INFORMATION

<u>Insured's Primary Physician</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

<u>Insured's Specialist # 1</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

<u>Insured's Specialist # 2</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

PRIMARY INSURED HOSPITAL INFORMATION

If insured has been hospitalized in the past 5 years, please fill in the following:

	Hospital (Include City & State)	Condition	Length of Stay
1			
2			
3			

(print additional pages if needed)

4 PRIMARY INSURED MEDICAL HISTORY

Height

Weight

Have you ever had any of the following?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/ Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Memory Loss |

Please provide additional details on the above conditions. *(Please include date of prognosis & treating physician)*

Within the past 12 months, has the primary insured received treatment or advice from a member of the medical profession for heart disease, diabetes, stroke, or cancer? Yes No

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco? Yes No

If so, please describe:

PRIMARY INSURED FAMILY HISTORY

Have Family Members Had:	Father	Mother	Siblings
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	If Living Age	If Deceased Age & Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		

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SECOND INSURED MEDICAL INFORMATION

<u>Second Insured's Primary Physician</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

<u>Second Insured's Specialist # 1</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

<u>Second Insured's Specialist # 2</u>		Date Last Seen
Physician's Address		
Telephone	Fax	
Reason Last Seen		

SECOND INSURED HOSPITAL INFORMATION

If insured has been hospitalized in the past 5 years, please fill in the following:

Hospital (Include City & State)	Condition	Length of Stay
1		
2		
3		

(print additional pages if needed)

SECOND INSURED MEDICAL HISTORY

Height _____

Weight _____

Have you ever had any of the following?

- | | | | |
|---|---------------------------------------|--|---|
| <input type="checkbox"/> Chest Pain/ Tightening | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> TB/Lung Disorder |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Skin Disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Depression | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Urinary Infections |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Hearing |
| <input type="checkbox"/> Dizzy Spells | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Memory Loss |

Please provide additional details on the above conditions. *(Please include date of prognosis & treating physician)*

Within the past 12 months, have you received treatment or advice from a member of the medical profession for heart disease, diabetes, stroke, or cancer? Yes No

Have you smoked cigarettes, cigars or pipes within the last year, or otherwise used tobacco, i.e. chewing tobacco? Yes No

If so, please describe:

SECOND INSURED FAMILY HISTORY

Have Family Members Had:	Father	Mother	Siblings
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	If Living Age	If Deceased Age & Cause of Death
Father		
Mother		
Brother(s)		
Sister(s)		



54 Broad Street, Suite 303
Red Bank, NJ 07701
(P) 732.842.2700
(P) 888.842.1842
(F) 888.842.0155

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured/Patient (Please type or print)

Date of Birth

First *MI* *Last* *Month / Day / Year*

I authorize any: person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, ("My Providers", reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle agency, employer, or any other person or institution ("Other Persons") to release to: each of the insurers listed below, as well as to their reinsurers, any insurance support organizations, and those persons authorized to represent them, and The CFS General Agency; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputation, finances, occupation, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. 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.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the insurers named below and their reinsurers will use this information to help determine my eligibility for insurance. The insurance agent may also use this information to help update and improve my insurance program.

I agree that the above named parties may also disclose my information to other insurers, reinsurers, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with the underwriting process, or as may be otherwise lawfully required.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to The CFS General Agency at the above Service Office address. I understand that a revocation is not effective if My Providers and Other Persons have relied on this Authorization or to the extent that an insurer named below has a 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by CFS except as authorized by me or as required by law.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. 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 carriers listed below may not be able to process my insurance application. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Client Initials: _____



54 Broad Street, Suite 303
 Red Bank, NJ 07701
 (P) 732.842.2700
 (P) 888.842.1842
 (F) 888.842.0155

Signature of Proposed Insured

Name of Proposed Insured

Signature of Additional Proposed Insured (if applicable)

Name of Additional Proposed Insured

City

State

Month / Day / Year

THIS HIPAA APPLIES TO THE FOLLOWING AUTHORIZED PARTIES / INSURERS:

- | | | |
|----------------------------------|------------------------------------|------------------------------|
| ALIR | Indianapolis Life | New York Life |
| Allianz Life Insurance Co. | ING | Ohio National |
| American General Life Ins. Co. | ILSA LLC | Pacific Life Insurance Co. |
| American National | Jackson National | Parameds.com |
| Banner | Jefferson Pilot Financial Ins. Co. | Phoenix Home Life |
| Berkshire Life Insurance Co. | John Hancock Life Ins. Co. | Principal Life |
| BIUS, Inc. | Kansas City Life | Protective Life |
| Canada Life Assurance Co. | Life of the Southwest | Prudential Life Ins. Co. |
| Columbus Life | Lincoln Benefit Life | Sun Life of Canada |
| Empire General Life Assurance Co | Lincoln National | State Life |
| F & G | Lincoln Financial | Transamerica Occidental Life |
| First Colony | Manufacturers Life Insurance Co. | Travelers Insurance Company |
| First Penn | Massachusetts Mutual Life Ins. | United of Omaha |
| Pacific Life Ins. Co. | Metropolitan Life Insurance Co. | Unum Life Insurance |
| GE Financial Assurance Co. | Midland National | USG |
| General American Life Ins. Co. | Minnesota Life | West Coast Life Insurance |
| Guardian Life Insurance Co. | MONY | Zurich Kemper |
| Hartford Life Insurance Co. | New England Life | |

Client Initials: _____