Associated Life Brokerage Preliminary Inquiry

This is NOT an application for life insurance. It is a preliminary evaluation to assist in determining insurability only.

Client Information

Name of Insured: ________________________ Soc Sec #: ______ - ______ - ______ Date of Birth:____ /_______ /_______

Address: ________________________ City: ____________________ State:___________ Zip: ___________

Home Phone: ____________________ Work Phone: ____________________ Gender: ☐ Male ☐ Female

Height: ____ft._____in. Weight:_______lbs Tobacco Use: ☐ Yes ☐ No If yes, type: ________________ Date last used:__________

Occupation: __________________ Employer: ____________________ Annual Income: $ ______________ Net Worth: $ ____________

Are you a US Resident? ☐ Yes ☐ No Are you a US Citizen? ☐ Yes ☐ No If either is No, what country? ______________

Coverage Information

Face Amount $________________ Policy Type: ☐ Indiv ☐ Surv ☐ UL ☐ GUL ☐ WL ☐ VUL

Proposed Premium: $ __________________ ☐ Single Pay ☐ Term Years level: ____ ☐ ROP State of Issue: __________________

Total insurance in-force now: $ __________________ Date last purchased:_____/_____/_____ Rated? ☐ Yes ☐ No

Will new insurance replace any in-force insurance? ☐ Yes ☐ No

Will this be a 1035 Exchange? ☐ Yes ☐ No If Yes, approximate exchange: $ __________________________

Have you ever been declined or rated for insurance? ☐ Yes ☐ No If Yes, please provide details: __________________________

Medical Provider Information

Name of Primary Care Physician: ________________________ Date Last Consulted: ______ /_______ /_______ Reason: ________________

Full Address:________________________________ City: ________________State: ____ Zip:________ Phone: (___) ____ - ______

Current diagnosis and medications: ____

Name of Specialist:________________________________Date Last Consulted:_______/_______ /_______ Reason: ________________

Full Address:________________________________ City: ________________State: ____ Zip:________ Phone: (___) ____ - ______

General Questions *(please check any items or activities from the list below that apply and provide details):*

A. ☐ Cardiovascular ☐ Heart ☐ Angina ☐ Stroke ☐ HBP

B. ☐ Cancer ☐ Location ___________________

C. ☐ Diabetes ☐ Type 1 ☐ Type 2 Age at dx: _____

D. ☐ Any other medical conditions including:
☐ mental/nervous ☐ respiratory ☐ urinary ☐ gastrointestinal

E. ☐ Drug Abuse ☐ Alcohol Abuse

F. ☐ Personal bankruptcy

G. ☐ Driving record ☐ DWI/DUI ☐ violations

H. ☐ Private aviation

I. ☐ Hazardous avocations:________________________

J. ☐ Travel or residence outside the US or Canada

K. ☐ Other

Details (A-K): ____
____

Agent/Financial Advisor To Complete This Section

Agent/Advisor Name: ______________________________ SSN:_____ - _____- ______ Email: ______________________________

Firm: ________________________________ Branch City: ______________________________ Business Phone (_____) _____ - ______

Licensed in: Residence state of insured ☐ Yes ☐ No Owner State ☐ Yes ☐ No Trust State ☐ Yes ☐ No

AGA Name:____CTP: ______________________

Authorization for Release of Health Related-Information

____ ____/____/_____

Name of Proposed Insured/Patient (First, Middle, Last) Date of Birth

I hereby 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 ("My Providers") to disclose my entire medical record and any other protected health information concerning me to ASSOCIATED LIFE BROKERAGE, Inc ("ALBI") and its agents, employees and representatives. This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information to be released may include, but are not limited to, the following: alcohol or drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKGs.

By signing below, I amend my agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction to ALBI.

My protected health information is to be disclosed under this Authorization so that ALBI may disclose this information to the insurance companies below for the following purposes: 1) underwrite my application for coverage by making eligibility, risk rating, policy certificate issuance and enrollment determinations; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with an insurance company. ALBI does not make insurance approval decisions regarding this protected health information.

Insurance companies with whom we may share the information:

ALBI	Companion Life	MetLife	New York Life	Protective
Allianz	Genworth	Midland National	North American	Prudential
American General	Guardian	Minnesota Life	Old Mutual	Symetra
American National	ING	Mutual of Omaha	Principal Life Ins Co	Transamerica
Aviva	John Hancock	National Western	Principal Nat'l Life Ins Co	William Penn
AXA	Lincoln Benefit Life	Nationwide	Penn Mutual	Other: _______________
Banner	Lincoln Financial Group			

This Authorization will remain in effect a maximum of twenty-four (24) months, or for the greatest timeframe allowed under applicable state laws, rules or regulations, following the date of my signature below and a copy of this Authorization is as valid as the original. I understand I have the right to revoke this Authorization in writing at any time, by sending a written request of revocation to: ALBI, 135 Rt 202/206 Bedminster, NJ 07921, but that my revocation will not be effective until it is received by My Providers. I understand that this revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that an insurance company has the legal right to contest a claim under an insurance policy/certificate or the contest the policy/certificate 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 understand that if I refuse to sign this Authorization, the insurance 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 I have received a copy of this Authorization.

____

Signature of Proposed Insured/Patient or Personal Representative Date

____

Description of Personal Representative's Authority or Relationship to Proposed Insured Patient