



Broker's Name                      Address                      Telephone Number                      Fax                      Email Address

### Applicant & Plan Information

FULL NAME:		DATE OF BIRTH:		SEX:	HEIGHT:	WEIGHT:
SOCIAL SECURITY NUMBER:		STATE OF RESIDENCE:	CITIZENSHIP:		OCCUPATION - POSITION:	
AMOUNT DESIRED:	TYPE OF PLAN:	PREMIUM EXPECTATION:	BENEFICIARY - RELATIONSHIP:		PURPOSE OF INSURANCE:	

If an application has been submitted within the last 6 months or will be submitted to another company, please provide the:

1. Company
2. Plan
3. Underwriting Classification
4. Premium offered or quoted
5. Please include a copy of the ledger with this Informal Evaluator

If this is a replacement case please provide:

1. Type of policy (term/include level premium period or permanent)
2. When issued
3. Company
4. Current premium
5. If an in force ledger has been prepared, include it with this Informal Evaluator

### Impairment Questions

**I. Cancer Questions**

- A. Date of diagnosis and start of treatment \_\_\_\_\_
- B. Date released from treatment \_\_\_\_\_
- C. Type of treatment:    \_\_\_Chemo \_\_\_Radiation \_\_\_Surgical
- D. **Type of cancer (provide path report when possible)**
- E. Stage, level or grade and location \_\_\_\_\_
- F. Type and frequency of follow up care \_\_\_\_\_
- G. Doctor with all cancer records and date last seen \_\_\_\_\_

**II. Coronary Questions**

- A. Heart Attack
  - a. Date of attack \_\_\_\_\_
  - b. Any subsequent chest pain \_\_\_\_\_
  - c. Results of catheterization \_\_\_\_\_
  - d. Results of last EKG or stress EKG with date \_\_\_\_\_
  - e. Current medication and dosage \_\_\_\_\_
  - f. Doctor with all heart records and date last seen \_\_\_\_\_
- B. Coronary Artery By-Pass or Angioplasty
  - a. Date of surgery \_\_\_\_\_
  - b. Number of vessels involved and which ones \_\_\_\_\_
  - c. Was there a prior heart attack    \_\_\_Yes \_\_\_No
  - d. Current medication and dosage \_\_\_\_\_
  - e. Results of last stress EKG with date \_\_\_\_\_
  - f. Any chest pain since surgery \_\_\_\_\_
  - g. Doctor with all heart records and date last seen \_\_\_\_\_

**III. Diabetes Questions**

- A. Date of diagnosis and age of onset \_\_\_\_\_
- B. Treatment: Diet only, Oral tablets, Insulin \_\_\_\_\_
- C. Type of self-testing and results, frequency of test \_\_\_\_\_
- D. Last Hemoglobin A1C test with date and results \_\_\_\_\_
- E. Treated for:
  - \_\_\_Insulin reaction                      \_\_\_Kidney trouble (albumin)
  - \_\_\_Diabetic coma                        \_\_\_Neuritis, neuralgia or neuropathy
  - \_\_\_Eye trouble                            \_\_\_Amputation
  - \_\_\_Heart trouble                         \_\_\_Skin problems or infections
  - \_\_\_High blood pressure                \_\_\_Poor circulation or leg cramps
- F. Doctor with all diabetes records and date last seen \_\_\_\_\_

**IV. Drug/Alcohol Questions**

- A. Type of usage and amounts \_\_\_\_\_
- B. Date of first use and date stopped \_\_\_\_\_
- C. Rehab center - date admitted, date released \_\_\_\_\_
- D. Involved in AA or other support group and frequency \_\_\_\_\_
- E. Any recurrences with dates \_\_\_\_\_
- F. Arrests for DWI or DUI \_\_\_\_\_

**V. Other Health History - Include dates of diagnosis and dates seen by attending physicians**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**IDENTIFY QUESTION NUMBERS AND PROVIDE DETAILS**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Background & History

NAME AND ADDRESS OF YOUR PERSONAL PHYSICIAN:

DATE AND REASON LAST CONSULTED:

CITY, STATE, ZIP CODE:

WHAT ADVICE OR TREATMENT WAS PRESCRIBED?

YES

NO

Please furnish complete details of any "YES" answers:

[ ]

[ ]

1. Have you used tobacco or nicotine products in any form? If yes, what and when?

[ ]

[ ]

2. Have you had life insurance declined, modified, rated, or its renewal refused?

[ ]

[ ]

3. Have either of your parents or any sibling died on or before age 60; if yes, please advise cause of death?

[ ]

[ ]

4. List all past and present medications and dosages.

### HIPAA Authorization for Release of Information (HIPAA - Health Insurance Portability and Accountability Act)

I hereby authorize Brokerage Unlimited, Inc. ("my Representative") and its staff, affiliated companies and/or entities, insurance companies and their re-insurers, to possess, obtain and/or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long term care, or other insurance products.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. 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.

By my signature below, I terminate any agreements I have made with my Providers to restrict my medical records and any associated HIPAA protected health information and I instruct my Providers to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of Brokerage Unlimited, Inc., affiliated insurance companies and their re-insurers.

The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Proposed Insured's Signature \_\_\_\_\_ Agent/Witness \_\_\_\_\_

Signed and Dated on \_\_\_\_\_ At \_\_\_\_\_  
(City, State, Zip Code)

Aegon  
AXA Equitable  
American General Companies  
American National  
AVIVA  
Banner

Genworth/GE  
ING Companies  
John Hancock  
LifeMark  
Lincoln Benefit  
Lincoln Life

MetLife  
Nationwide  
Protective  
Prudential  
Savings Bank Life (SBLI)  
Sun Life

Transamerica  
United of Omaha  
William Penn  
West Coast Life