INFORMAL INQUIRY

Not an application for life insurance

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers. Minimum for informal review is $2,000,000 of DB for term and $1,000,000 of DB for permanent; or $10,000 of premium.

PRODUCER INFORMATION

Producer: ______________________ Date: ______________________

Face Amount: ______________________ Product: ______________________

PROPOSED INSURED INFORMATION

Applicant Name: ______________________ ☐ Male ☐ Female DOB: ______________

SS#: ______________________ Drivers License #: ______________________

Street Address: ____

City: ______________________ State: ______________________ Zip Code: ______________

Primary Phone Number: ______________________ ☐ Home ☐ Work ☐ Mobile

Alternate Phone Number : ______________________ ☐ Home ☐ Work ☐ Mobile

Occupation: ______________________ Income: ______________________

Assets: ______________ Liabilities: ______________________ Net Worth: ______________________

Premium Tolerance/Offer needed to place: ____

Can you provide Third Party Financials signed by a currently licensed CPA? ☐ Yes ☐ No

INSURANCE CURRENTLY IN FORCE

Company	Year Issued	Face Amount	Being Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

ACTIVITY AND MEDICAL INFORMATION

Do you participate in any hazardous activities? ☐ Flying ☐ Scuba ☐ Climbing ☐ Other

Details: ____

Do you have any plans for foreign travel? ☐ Yes ☐ No

Details: ____

Have you ever used any kind of tobacco product? ☐ Yes ☐ No

Forms Used: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ______________

Date last used: ______________________

Do you have any knowledge that an application or informal inquiry has been seen by any carrier in the last year?

☐ Yes

☐ No

Company	Offer	Placed?

Height: ______________________________ Weight: _________________________________

ACTIVITY AND MEDICAL INFORMATION, CONTINUED

Do you have a history of:

High Blood Pressure ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease ☐ Yes ☐ No

☐ Heart Attack ☐ Bypass Surgery Date of event: __________________________

☐ Stent(s) Date of Last EKG/Stress Test: __________________________

Diabetes ☐ Yes ☐ No

At what age were you diagnosed? __________________________

List all diabetes medications currently prescribed:

Medication: __________________________ Dosage: __________________________

Medication: __________________________ Dosage: __________________________

Medication: __________________________ Dosage: __________________________

Most recent A1c level: ____________ Current glucose reading: __________________________

Respiratory Disease ☐ Yes ☐ No

Have you been hospitalized for this condition: ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you curently using a CPAP? ☐ Yes ☐ No

Date of last pulonary function test: __________________________

Cancer ☐ Yes ☐ No

Type of cancer: ____

Was there a biopsy? ☐ Yes ☐ No Cancer stage if known: ____________

Date of surgery, if any? ____

Date of completion of radition treatment: ____

Date of competion of chemotherapy: ____

Please list any medical conditions not indicated above: __________________________

____

____

FAMILY MEDICAL HISTORY

Family Member	Age If deceased, age @ death and cause	History of Heart Disease?		History of Cancer?		Type
Mother		☐ Yes	☐ No	☐ Yes	☐ No	
Father		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 1		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 2		☐ Yes	☐ No	☐ Yes	☐ No	

SENIOR SUPPLEMENT

Have you been diagnosed with Alzheimer's or dementia? ☐ Yes ☐ No

Have you ever been treated for memory problems? ☐ Yes ☐ No

Do you require assistance for walking? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Do you exercise on a daily basis? ☐ Yes ☐ No

Do you require assistance with daily chores? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been diagnosed with depression? ☐ Yes ☐ No

Have you ever been diagnosed with anemia? ☐ Yes ☐ No

Please provide details of any "Yes" answers above: __________________________

SENIOR SUPPLEMENT, CONTINUED

Please list all medications being taken: ______________________________

PHYSICIAN INFORMATION

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________________

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________________

PHYSICIAN INFORMATION, CONTINUED

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________________

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________________

ADDITIONAL NOTES

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, RD Marketing Group, brokers, contractors, employees, representatives and agents working through RD Marketing Group for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
RD Marketing Group American National Assurity Life Accordia Life/Global Atlantic Ameritas AXA / MONY / AXA Equitable Brighthouse Financial Corebridge Financial Corbridge Financial Partners Group Examination Management Services, Inc Express Imaging Services. Global Atlantic John Hancock Life Ins. Co. John Hancock USA Life Insurance of the Southwest Lincoln Financial/ Lincoln Life Lincoln National Life Insurance Co. MassMutual	Minnesota Life / Securian Mutual of Omaha National Life Group Nationwide Life & Annuity Co. New York Life Insurance Co. North American Co. OneAmerica/State Life Principal Life Insurance Company Principal National Life Insurance Company Protective Life Ins Co. Prudential Life Ins. Co. / Pruco Life Sagicor Symetra Transamerica Life Insurance Co. Union Central Life United of Omaha Zurich American Life Insurance Company		
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 RD Marketing Group, 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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation; personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 866-692-6901.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.