AARON ADVANTAGE AGENCY

Informal Inquiry

Not an Application for Life Insurance

Date: _____ **Producer:** _____
Face Amount: _____ **Product Type:** _____

PERSONAL INFORMATION

Applicant: _____ ☐Male ☐Female **DOB:** _____
SS#: _____ **Driver's License #:** _____ **Place of Birth:** _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Contact Phone Number: _____ ☐Home ☐Work ☐Mobile ☐Other
Alternate Phone Number: _____ ☐Home ☐Work ☐Mobile ☐Other
Occupation: _____ **Income:** _____
Assets: _____ **Liabilities:** _____ **Net Worth:** _____
Premium Tolerance/Offer Needed to Place: _____
Can you provide 3rd party financials signed by a currently licensed CPA? ☐Yes ☐No

INSURANCE CURRENTLY IN FORCE

Company	Year Issued	Face Amount	Replace?	Offer to be Replaced
			☐Yes ☐No	
			☐Yes ☐No	
			☐Yes ☐No	
			☐Yes ☐No	

ACTIVITY AND MEDICAL INFORMATION

Do you participate in any hazardous activities? ☐Flying ☐Scuba Diving ☐Mountain Climbing ☐Other: _____
Do you have any plans for foreign travel? ☐No ☐Yes (If Yes, please advise when, where, purpose and how long below)

_____

Have you ever used any kind of tobacco or any other products containing nicotine? ☐No ☐Yes (If Yes, complete the following)
What form of tobacco was used: ☐Cigarette ☐Pipe ☐Nicotine Gum/Patch ☐Cigar (How many per year? _____)
☐Other: _____
Has use been discontinued? ☐No ☐Yes (Date Discontinued: _____)

Do you have any knowledge that an application or informal inquiry has been seen by any carriers within the last year?
☐No ☐Yes:

Company	Year Issued	Decline
		☐
		☐
		☐

Height: _____ **Weight:** _____
Do you have a history of…
High Blood Pressure? ☐No ☐Yes (What medications were you taking? _____)
Heart Condition/Coronary Artery Disease? ☐No ☐Yes (If Yes, complete the following)
☐Heart Attack ☐Bypass When did the event occur? _____
☐Stent(s) (How many vessels affected? _____) When was the last EKG Stress Test? _____

Diabetes? ☐No ☐Yes – Type1 ☐Yes – Type2 (If Yes, complete the following)

At what age were you first diagnosed? _____

List Medications Being Taken: _____

Last A1C Numbers: _____ Last Glucose Readings: _____

What is the therapy and doses at the present time? _____

Respiratory Disease? ☐No ☐Yes (If Yes, complete the following) Check as appropriate: ☐Asthma ☐COPD

Have you ever been hospitalized? ☐No ☐Yes Have you ever been diagnosed with Sleep Apnea? ☐No ☐Yes

Currently using CPAP: ☐No ☐Yes (Date: _____) Last Pulmonary Function Test? _____

Cancer? ☐No ☐Yes (If Yes, complete the following)

Type of Cancer: _____ When were you diagnosed? _____

Was there a biopsy? ☐No ☐Yes What is the stage of the cancer? _____

What are the dates of radiation or chemotherapy: _____

List any medical conditions not indicated above:

_____

FAMILY MEDICAL HISTORY

Family Member	Age *(if deceased, age at death)*	History of Heart Disease	History of Cancer *(all types)*
Mother		☐No ☐Yes	☐No ☐Yes (Type(s):)
Father		☐No ☐Yes	☐No ☐Yes (Type(s):)
Sister(s)		☐No ☐Yes	☐No ☐Yes (Type(s):)
Brother(s)		☐No ☐Yes	☐No ☐Yes (Type(s):)

SENIOR SUPPLEMENT (70+)

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

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

Do you require assistance for walking? ☐No ☐Yes

Do you have a history of falls? ☐No ☐Yes (If so, please explain below)

_____

Do you exercise on a daily basis? ☐No ☐Yes (How many hours? _____)

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

Do you drink alcohol? ☐No ☐Yes

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

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

Please explain any answers provided above: ☐No ☐Yes

_____

List Medications Being Taken:

_____

PHYSICIAN INFORMATION

List all Physicians seen within the past ten (10) years:

Physician Name: _____ **Phone:** _____

Address: _____

Date Last Seen: _____ **Reason:** _____

Physician Name: _____ **Phone:** _____

Address: _____

Date Last Seen: _____ **Reason:** _____

Physician Name: _____ **Phone:** _____

Address: _____

Date Last Seen: _____ **Reason:** _____

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, Aaron Advantage Agency, brokers, contractors, employees, representatives and agents working through Aaron Advantage Agency for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Aaron Advantage Agency	**Fidelity & Guaranty Life Ins. Co.**	**Advanced Settlements**	**Presidential Life**
Advantage Insurance Network, Inc.	**First Global Financial & Insurance**	**Life Insurance of the Southwest**	**Principal Life**
Accordia	**First Insurance Funding**	**LifeShare**	**Principal National Life**
Allianz	**First Penn**	**Lincoln Benefit Life**	**Professional Underwriting Services**
American General Life (AIG)	**Foresters**	**Lincoln Financial/ Lincoln Life**	**Protective Life Ins Co.**
American National	**General American Life Ins. Co.**	**Lincoln National Life Insurance Co.**	**Prudential Life Ins. Co. / Pruco Life**
Americo	**Global Insurance Underwriters**	**Massachusetts Mutual**	**SBLI**
Assurity Life	**GE Financial Assurance Co.**	**Metropolitan Life**	**Southern Capital Brokerage**
Aviva / Indianapolis Life	**Genworth Life Insurance Co.**	**MetLife Investors USA Insurance Co.**	**Southern Farm Bureau**
Ameritas	**Genworth Life and Annuity**	**Minnesota Life / Securian**	**Standard Life**
AVS, LLC	**Guardian Life Ins. Co.**	**Mutual of Omaha**	**Sun Life Ins. Co. of America**
AUS Underwriting	**Hartford Life Insurance Co.**	**National Life of Vermont**	**Sun Life Ins. Co. of Canada**
AXA / MONY / AXA Equitable	**Industrial Alliance Pacific**	**National Western**	**Symetra**
Banner Life	**ING - ReliaStar Life of New York**	**Nationwide Life & Annuity Co.**	**Transamerica Life Insurance Co.**
Beneficial Financial Group	**ING – ReliaStar**	**New Investor World, Inc.**	**Travelers Life & Annuity**
Bragg Associates	**VOYA**	**New York Life Insurance Co.**	**21st Services**
Columbus Life	**ING - Security Life of Denver**	**North American Co.**	**Union Central Life**
Concord Capital/INSCAP	**ISC Services**	**Old Mutual Financial Network**	**United of Omaha**
Coventry First, LLC	**John Hancock Life Ins. Co.**	**Pacific Life**	**USG Annuity & Life**
Equity Key, LLC	**John Hancock USA**	**Penn Mutual**	**West Coast Life Insurance Co.**
Equity Release	**Kestler Financial**	**Premium Funding Group (PFG)**	**Western Reserve Life**
Examination Management	**Lafayette Life**	**Pioneer Mutual**	**William Penn Life Ins. Co.**
Services, Inc.	**Lewis and Ellis, Inc.**	**Phoenix Life**	**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 Aaron Advantage Agency, 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: 612.426.3660.

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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION