

PRELIMINARY INQUIRY – NOT AN APPLICATION FOR LIFE INSURANCE R 1-11

PERSONAL HISTORY			
Name _____		<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address _____		Social Security # _____	
City _____		State _____ Zip _____	
Home Phone: _____		Business Phone: _____	
Date of Birth _____		Age _____	
Height _____		Weight _____	
When last used tobacco? _____		Cigarettes _____	
Cigars _____		Other _____	
Hazardous Activities: Private Pilot: <input type="checkbox"/> Yes <input type="checkbox"/> No		Scuba Diving: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Sky Diving: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Health History:	Age (If deceased, age at death)	History of heart disease or circulatory disorder	History of cancer, all types
Mother		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Father		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED			
<input type="checkbox"/> Universal Life		<input type="checkbox"/> Whole Life	
<input type="checkbox"/> Term		<input type="checkbox"/> Survivorship	
Face amount desired \$ _____		Premium Amount desired \$ _____	

MEDICAL HISTORY – THIS SECTION MUST BE FULLY COMPLETED		
1. Who is your personal physician?	Doctor's name, address and phone number	When did you last consult him/her? Date _____ Reason _____
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations)		
3. In what clinics, hospitals, or sanitariums have you ever been treated?		
4. Please list all current medications:		

Has the person to be covered had:	YES	NO
A. Epilepsy, fainting spells, nervous or mental condition, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?	_____	_____
B. Heart attack, murmur, palpitations, or high blood pressure, anemia, varicose veins or any disease or abnormality of the heart, blood or blood vessels?	_____	_____
C. Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?	_____	_____
D. Ulcer, indigestion, colitis, gall stones, hernia or any disease or abnormality of the stomach, intestines, rectum, gall bladder or liver?	_____	_____
E. Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate urinary or genital systems?	_____	_____
F. Diabetes, gout, or any disease or abnormality of the thyroid or other glands?	_____	_____
G. Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?	_____	_____
H. Any disease or abnormality of the eyes, ears, or skin?	_____	_____
I. Cancer or tumor?	_____	_____
J. Any physical deformity or defect?	_____	_____
K. Any immune deficiency disorder, been diagnosed as having ARC or AIDS caused by HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection?	_____	_____
L. Decline or rating for life insurance	_____	_____
M. Rating for life insurance	_____	_____

FOREIGN TRAVEL
Do you plan to travel or live outside of the US in the next 5 years? <input type="checkbox"/> YES <input type="checkbox"/> NO
If so, where and for how long? _____

AGENT INFORMATION

Name _____ Firm Name _____ SSN# _____
 Address _____ City _____ State _____ Zip _____
 Phone _____ Email _____

Please send your completed documents to: Pinnacle, 7791 Belfort Parkway, Jacksonville, FL 32256, Attn – Underwriting
 Phone – 904-296-4100 Fax – 904-296-2352 Email – pat.gulbrandsen@pinnacleIFS.com

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: _____

THE COMPANIES:	
Advantage Insurance Network	2801 Towngate Rd. Suite 350, Westlake Village, CA 91361
Advanced Settlements, Inc.	2101 Park Center Drive, Suite 200, Orlando, FL 32835
American General Life Companies	750 West Virginia Street, Milwaukee, WI, 53204-1539
Allianz	PO Box 1344, Minneapolis, MN 55416-1297
American National	New Business Department, 1 Moody Plaza, Galveston, TX 77550-7947
Apex Underwriting Solutions, LLC	115 Canterbury Circle, East Longmeadow, MA 01028
Aviva	New Business, 611 Fifth Avenue, Des Moines, IA 50309-1603
AXA-Equitable Life	New Business Department, 80 Scott Swamp Road, Farmington, CT 06032-2847
Banner Life	1701 Research BLVD, Rockville, Maryland 20850-3131
Executive Marketing Insurers	207 W. Hickory Street, Suite 100, Denton, TX 76201
Foresters	PO Box 179, Buffalo, NY 14201
Genworth	3100 Albert Lanford Drive, Lynchburg, VA 24501-4996
IBU, Inc.	100 Pearl Street, 14th Floor • Hartford, CT 06103
ING/Reliastar Companies	Life New Business, 2000 21 st Avenue NW, Minot, ND 58703-0890
John Hancock Life Insurance	Life New Business, 200 Bloor Street East, Toronto, Ontario, M4W1E5, Canada
Lincoln Benefit	Life New Business, 2940 South 84 th Street, Lincoln, NE 68506-4142
Lincoln Financial Group	350 Church Street, Hartford, CT 06103-1106
Life Insurance Solutions, LLC	7791 Belfort Parkway, Jacksonville, FL 32256
Met Life	One City Place 185 Asylum Street, Hartford CT 06103-3401
Minnesota Life Insurance	400 Robert Street North, St. Paul, MN 55101
National Life Group	1 National Life Drive, Montpelier, VT 05604-1000
Nationwide Life	One Nationwide Plaza, Columbus, OH 43215-2220
New York Life Insurance Company	51 Madison Avenue, Suite 3200, New York, NY 10010
Pacific Life Insurance Co.	26642 Town Centre Drive, Room 42-3, Foothill Ranch, CA 96210-2808
Pan-American Life Insurance Group	601 Poydras Street, New Orleans, LA 70130
Phoenix Life Insurance Co.	30 Dan Road, Canton, MA 02021
Pinnacle Insurance and Financial Services, LLC	7791 Belfort Parkway, Jacksonville, FL, 32256
Principal Life Insurance Co	IDPC – 8 th -Floor 801, Grand Ave, Des Moines, IA 50392-2706
Protective Life Insurance Co.	New Business Department, 2801 Highway 280 South, Birmingham, AL 35223
Prudential Financial	Life New Business, 2102 Welsh Road, Suite DTY, Dresher, PA 19025-5500
Sun Life Assurance Co. of Canada	SC1215, One Sun Life Park, Life New Business, Wellesley Hills, MA 02481
Transamerica Life Insurance Co.	Life New Business, 4333 Edgewood Road NE, Cedar Rapids, IA 52499-0001
West Coast Life	Life New Business, 343 Sansome Street, San Francisco, CA 94104-1303

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits

If for a Lifetime Settlement, I understand that settlement providers and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner, or which I am the insured, and I hereby expressly authorize such use and disclosure.

Signed at _____ this _____ day of _____ 20_____

 Proposed Insured Signature

 Proposed Owner's Signature

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

 Name of Minor Child

 Signature of Minor Child's Authorized Representative

 Name of Minor Child's Authorized Representative

 Witness (Broker)

Authorization for Release of Health-Related Information - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
_____	_____
_____	_____
_____	_____

I 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 within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). 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. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal 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 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 further understand that if I refuse to sign this authorization to release my complete medical record, The 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 that I have received a copy of this authorization.

_____ Signature of Proposed Insured, Patient, or Personal Representative	_____ Date
_____ Signature of Proposed Insured, Patient, or Personal Representative	_____ Date
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Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Personal Psychotherapy Notes - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
_____	_____
_____	_____
_____	_____

I 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 within the past 10 years ("My Providers") to disclose my entire medical record and any other personal health information solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record as described above without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Companies.

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