

**Informal Inquiry (Not a Formal Application for Life Insurance)**  
**Confidential/For Internal Use Only**



Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Best Contact Phone Number: \_\_\_\_\_

Best Address for Paramed Exam to be completed: \_\_\_\_\_

**Medical Records:**

Life insurance often requires medical records for final approval on most face amounts. The process of acquiring medical records from your physicians is often times a slow process. Having nurses copy medical charts is tedious and takes time. We ask that you disclose any physician you have seen in the past 5 years so that we can promptly order all required records. This includes all specialists (Cardiologist, Dermatologist, Gastroenterologist, ENT, Sleep Studies, Oncologist, Pulmonologist, Orthopedic, Hospitals that you were admitted to, etc.) Knowing this history will help us gather documentation quickly for a more pleasant underwriting experience. Failure to disclose physician information to us will cause significant delays in the underwriting process.

Doctor 1: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Type: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Doctor 2: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Type: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Doctor 3: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Type: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Doctor 4: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Type: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Doctor 5: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Type: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_



HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured/Patient (Please type or print)

Date of Birth

First MI Last

Month/Day/Year

I authorize any: person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle agency, employer, or any other person or institution to release to: each of the insurance companies listed below, as well as to their reinsurers, any insurance support organizations, and those persons authorized to represent them, and Exclusive Insurance Brokerage; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputation, finances, occupation, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand that the insurers named below and their reinsurers will use this information to help determine my eligibility for insurance. The insurance agent may also use this information to help update and improve my insurance program.

I agree that the above named parties may also disclose my information to other insurers, reinsurers, the Medical Information Bureau, Inc., and other persons or organizations performing business or legal services in connection with the underwriting process, or as may be otherwise lawfully required.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Exclusive Insurance Brokerage at the above Service Office address. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Exclusive Insurance Brokerage except as authorized by me or as required by law.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder. 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 carriers listed below may not be able to review my medical file. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of proposed insured

Name of Proposed Insured

City

State

Month / Day / Year

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- List of insurance carriers including Accordia/Global Atlantic, Allianz, American General Life Ins. Co., American National, AMRITA Financial, Assurity Life, Axcelus Financial, Banner, Crump, ExamOne, Equitable Life Ins. Company, Exclusive Insurance Brokerage, Genworth, Global Atlantic, Guardian Life Insurance Co., Investor's Preferred Life, John Hancock Life Ins. Co., Life of Southwest, Lincoln Benefit Life, Lincoln Financial Group, Metropolitan Life Insurance Co., Minnesota Life, National Life, National Western, Nationwide, New York Life, North American, Old Mutual, Pacific Life Insurance Co., Penn Mutual, Principal Life, Protective Life, Prudential Life Ins. Co., Security Mutual, Standard Life, Sun Life of Canada, Superior Medical Group, Symetra, Tellus, Transamerica Life Insurance Co., Union Central, United of Omaha, Voya Financial, Zurich.