Clear Form

Life Insurance

Individual Application Data Collection Form

Agent:		Date:	

This life insurance data collection form will help us prefill the application to completion.

Full Legal Name:		Gender:	
Date Of Birth:		Social Security No.:	
Primary Phone:		Email Address:	
Street Address:		City, State, Zip:	
Driver's License#:		Expiration Date:	
DL Resident State:		US Citizenship:	**Y | N**
Birth State:		Marital Status:	
Tobacco Use:	**Y | N** **If Yes, please specify**	Marijuana Use:	**Y | N** **If Yes, please specify**
Height:		Weight:	
Approximately how long have you known the financial advisor or insurance professional?:			

Beneficiaries (Note additional beneficiaries in the overflow section)

Full Legal Name:		Percent:	
Relationship:		Type:	Primary | Contingent
SSN | Tax ID:		DOB | Established:	
Full Legal Name:		Percent:	
Relationship:		Type:	Primary | Contingent
SSN | Tax ID:		DOB | Established:	
Full Legal Name:		Percent:	
Relationship:		Type:	Primary | Contingent
SSN | Tax ID:		DOB | Established:	

Employment & Suitability

☐ **Employed** ☐ **Self Employed** ☐ **Unemployed** ☐ **Retired**

☐ **Homemaker** ☐ **Disabled** ☐ **Student** **Tax Rate:** **%**

Retirement Age:		Occupation:	
Name of Employer (Former if retired):			

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Select All Sources Of Income That Apply

- ☐ **Salary/Wages**
- ☐ **Social Security**
- ☐ **403(B)**
- ☐ **401K | Pension**
- ☐ **Inheritance/Gifts**
- ☐ **Non-Qualified Investments**
- ☐ **Qualified Investments**
- ☐ **Sale of Business or Property**

$	Insured Estimated Annual Gross Income
$	Household Net Worth (Including Real Estate)
$	Household Liabilities (Including Real Estate)

Current Insurance Coverages

Insurance Company	Death Benefit	Cash Value	Policy Number	Individual or Group Coverage	Issue Date (Approximate if unknown)	Replacement? Yes or No

Physician's Information

Insurance Companies will want to see the past 5 years of all medical records. To expedite the record retrieval process, please list any and all providers seen **in the past 5 years**.

Physician or Group Name	Address	Phone Number	Date of Last Visit	Purpose of Seeing Doctor

Overflow/Any Other Pertinent Information

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INSURANCE BROKERAGE

Life Insurance

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN & DISCLOSE INFORMATION

Full Legal Name:		Date Of Birth:	

- 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: Date Signed:

Print Name: City & State of Signature:

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:			
Accordia/Global Atlantic	ExamOne	MassMutual	Prudential Life Ins. Co.
Allianz	Exclusive Insurance Brokerage	Minnesota Life	Security Mutual
American General Life Ins. Co.	Genworth	National Life	Standard Life
American National	Global Atlantic	National Western	Sun Life of Canada
AMRITA Financial	Guardian Life Insurance Co.	Nationwide	Superior Medical Group
Assurity Life	Hartford Life Insurance Co.	New York Life	Symetra
Axcelus Financial	Investors Preferred	North American	Tellus
Banner	John Hancock Life Ins. Co.	Pacific Life Insurance Co.	Transamerica Life Insurance Co.
Beneficial Financial Group	Life of Southwest	Penn Mutual	United of Omaha
Crump	Lincoln Financial Group	Principal Life	Voya Financial
Equitable	Metropolitan Life Insurance Co	Protective Life	Zurich