

INFORMAL INQUIRY FORM

All questions contained in this questionnaire are strictly confidential and will be part of your medical record.

Name (last, first, M.I.)	Telephone:	DOB:	Height:	Weight:
Address:		City, State, Zip		
Primary Doctor:	Telephone:	Date of last visit:		
Address:		City, State, Zip		
List of Specialists:				
Doctor's Name	Specialty:	Telephone:		
Doctor's Name	Specialty:	Telephone:		

PERSONAL HEALTH HISTORY

Please check the boxes below for all those that apply	Details of "Yes" Answers
1. Have ever been treated for or had any indication of:	
a. Disorder of the eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Dizziness, fainting, convulsions, headache, speech defect, Paralysis, or stroke, mental or nervous disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No e. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Sugar, albumin, blood or pus in the urine, venereal disease, nephritis, stone, and or disorder of the kidney, bladder, prostate or reproductive organs? <input type="checkbox"/> Yes <input type="checkbox"/> No g. Diabetes, thyroid, or other endocrine disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones? <input type="checkbox"/> Yes <input type="checkbox"/> No i. Deformity, lameness, or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No j. Disorder of skin, lymph glands, cyst, tumor, or cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No k. Allergies, anemia, or other disorder of the blood? <input type="checkbox"/> Yes <input type="checkbox"/> No	Include give dates, diagnosis, details and treatment. Be sure to include names and addresses of all attending physicians and medical facilities
2. In the past 10 years have you:	
a. Had or been told you have or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Tested positive for antibodies to AIDS (Human T Cell Lymphotropic, Type III;HTLV-III) virus? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Have you ever:	
a. Used or currently use barbiturates, amphetamines, hallucinogenic drugs (including Marijuana), narcotics, or any prescription drug except in accordance with a physician's instruction? <input type="checkbox"/> Yes <input type="checkbox"/> No b. Received counseling advice or treatment regarding the use of alcohol or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Are you currently receiving any medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Other than in any items already listed, have you, within the past 5 years, been a patient in a clinic, sanitarium, or hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Have you ever used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If you quit, when did you stop using tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Have used any tobacco products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Do you currently use a nicotine patch or other nicotine product to help stop smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEART

Have you had any of the following:

High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Last BP Reading:
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	Total Chol. Level:
History of Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Evaluated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. of attacks:

Any resulting impairments:

By-Pass Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. of vessels:	Name of Vessels:	Date:
Coronary Angioplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. of vessels:	Name of Vessels:	Date:
Stent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which vessels:		
Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. of times:	Congestive? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Valve Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Valve:		Date:
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	Date:	

Atrial Fibrillation: Chronic Single Episode

Premature Ventricular Beats (PVC's)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Premature Supraventricular Atrial Beats (PAC's)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last electrogram:	<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal	Attending Physician:	

Where any of the following tests completed:

Stress Electrocardiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. of vessels:	Attending Physician:	Date:
Echocardiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	Done while exercising?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Thallium Stress EKG	<input type="checkbox"/> Yes <input type="checkbox"/> No	Attending Physician:		Date:
Coronary Angiogram	<input type="checkbox"/> Yes <input type="checkbox"/> No	No. diseased vessels:	Attending Physician:	Date:

CANCER

Location of Cancer:	Diagnosis Date:
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Exact name of Cancer:

Who would have the Pathology report?	Number of adjacent Lymph Nodes with abnormal cells:
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Any radiation or Chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last treatment:
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Has there been any reoccurrence of cancer?

IF skin cancer, was it melanoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clarks or Breslows Thickness rating:
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IF prostate cancer:	Gleason Score:	Staging:
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PSA at Diagnosis	Current PSA:	Treatment:
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DIABETES

Date of diagnosis:	Treatment:	Name of Medication:
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Weight 1 yr ago:	Weight now:	Height:
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How often are sugar levels monitored?

Date of last test:	Results:
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Last Hemoglobin A1C reading:	Date:
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Last MicroAlbumin level:	Date:
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Last Glucose Level:	Date:
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Any complications? (e.g. eyes, heart, kidney, etc.) Yes No

Details:

FAMILY HISTORY

	Age if living	Age at death	History of Cardiovascular Disease	Age of onset	History of Cancer	Age of onset
Father			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Siblings			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	This form is HIPAA compliant
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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, **Edison Risk, LLC**, brokers, contractors, employees, representatives and agents working through **Edison Risk, LLC** for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Allianz American General Life (AIG) American National Americo Assurity Life Aviva / Indianapolis Life Ameritas AVS, LLC AUS Underwriting AXA / MONY / AXA Equitable Banner Life Beneficial Financial Group Bragg Associates Broker's Alliance Columbus Life Concord Capital/INSCAP Edison Risk, LLC Equity Key, LLC Equity Release Examination Management Services, Inc. Fasano Associates, Inc. First Choice Brokerage Fidelity & Guaranty Life Ins. Co.	First Global Financial & Insurance First Insurance Funding First Penn Foresters General American Life Ins. Co. Global Insurance Underwriters GE Financial Assurance Co. Genworth Life Insurance Co. Genworth Life and Annuity Guardian Life Ins. Co. Hartford Life Insurance Co. Industrial Alliance Pacific ING - ReliaStar Life of New York ING - ReliaStar ING - Security Connecticut Life ING - Security Life of Denver ISC Services John Hancock Life Ins. Co. John Hancock USA Kestler Financial Lafayette Life Lewis and Ellis, Inc. Life Distributors of America, LLC Life Insurance of the Southwest	LifeShare Lincoln Benefit Life Lincoln Financial/ Lincoln Life Lincoln National Life Insurance Co. Massachusetts Mutual Metropolitan Life MetLife Investors USA Insurance Co. Minnesota Life / Securian Mutual of Omaha National Life of Vermont National Western Nationwide Life & Annuity Co. New Investor World, Inc. New York Life Insurance Co. North American Co. Old Mutual Financial Network One America/State Life Pacific Life Penn Mutual Premium Funding Group (PFG) Pioneer Mutual Phoenix Life Prudential Life Principal Life Insurance Company Principal National Life Insurance Company	Professional Underwriting Services Protective Life Ins Co. Prudential Life Ins. Co. / Pruco Life Royal Neighbors of America RSA Medical Sagicor SBLI Security Mutual Standard Life Sun Life Ins. Co. of America Sun Life Ins. Co. of Canada Superior Medical Group Symetra Transamerica Life Insurance Co. Travelers Life & Annuity 21st Services Union Central Life United of Omaha USG Annuity & Life West Coast Life Insurance Co. Western Reserve Life William Penn Life Ins. Co. 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 **Company Name**, 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: _____

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.