

# CONFIDENTIAL LIFE INSURANCE QUESTIONNAIRE

## Preliminary Inquiry—Not an application for life insurance.

To help you obtain competitive life insurance quotes, please provide information on your medical history, doctors and other factors that may impact underwriting. This preliminary inquiry is not an actual application for insurance and does not guarantee any coverage will be offered. This information is held confidential and released only to parties named below.

PERSONAL INFORMATION					
<b>Producer Name:</b>					<b>Date:</b>
Client Name: First		Middle Initial		Last	SSN
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth		Citizenship		Driver's License Info:	State #
Present Address:		City		State	Zip
Proposed Amount of Insurance:		Purpose of Insurance <input type="checkbox"/> Personal <input type="checkbox"/> Business		Plan <input type="checkbox"/> Term <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Survivorship	Type <input type="checkbox"/> Fixed <input type="checkbox"/> Index <input type="checkbox"/> Variable
Occupation, Type of Business, Position			Average Annual Income		Net Worth

EXISTING INSURANCE COVERAGE			
What is the total amount of life insurance on your life (including any provided by your employer)?			
Company Name	Death Benefit	Year Issued	Beneficiary
Will the insurance being applied for replace, change or affect any of the insurance noted above? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, which policies?			
Do you have any other pending (or anticipated) applications for life insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide insurance company name, face amount, date of application)			
Have you ever had any life insurance application declined, rated, postponed, withdrawn, modified, canceled, or not renewed? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list date and reason)			

TOBACCO USE	
Have you ever used any form of tobacco or nicotine products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
(If yes, type and quantity used) <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars/Cigarillos <input type="checkbox"/> Pipe <input type="checkbox"/> Smokeless <input type="checkbox"/> Nicotine delivery systems (including gums, inhalers, lozenges, patches, wafers, etc.)	
If Yes, are you a current user? <input type="checkbox"/> Yes <input type="checkbox"/> No use	If No, date of last use: / /

HEALTH AND MEDICAL INFORMATION	
Height ____ft. ____in.	Weight ____ lbs.
Please list medical conditions noted over the past 10 years.	Please list current or recent medications.
Have you ever been told you had any of the following conditions? <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Disease (including coronary artery disease, chest pain or angina, heart attack, heart enlargement, murmur, valve problem, etc.)	
<input type="checkbox"/> Lung Disease (including asthma, emphysema, bronchitis, etc.) <input type="checkbox"/> Cancer (including melanoma) <input type="checkbox"/> Stroke	
<input type="checkbox"/> Diabetes Mellitus <input type="checkbox"/> Dementia or Memory Loss <input type="checkbox"/> Hepatitis B or C <input type="checkbox"/> Reduced Kidney Function	

MEDICAL HISTORY			
Physician Information (all doctors seen in the past 10 years)			
Physician name, address & phone number	Approximate dates or timeframes of visits	Medical findings/assessments for those visits	Treatment provided or recommended

ALCOHOL OR DRUG ABUSE			
Have you ever:			
1) Sought or received medical advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2) Used any non-prescription controlled substances, including cocaine, marijuana, heroin, amphetamines, barbiturates, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3) Had a prescription for marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide details:			
Type of drug(s)/alcohol products(s):		Date last used:	
Frequency of use: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Amount usually used:	
Name(s) of doctor/facility			Phone:
Address		City	State      Zip
Treatment Dates			
Support Group(s)			Last Date Attended
Was the treatment or support group attendance court ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Details of any drug or alcohol-related arrests:			

FAMILY HISTORY					
Age if Living	Age at Death	Cause of Death	History of Heart Disease	History of Cancer?	If yes, type of Cancer
Father			<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	
Mother			<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	
Sister(s)			<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	
Brother(s)			<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes Age of Onset _____	

FOREIGN TRAVEL OR RESIDENCE			
Is foreign <b>travel</b> or <b>residence</b> contemplated within the next two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete the following and list each trip separately:			
Destination (City, Country)	Anticipated Departure Date	Anticipated Duration of Travel or Residence	Purpose of Travel
Please provide details on: any home or business owned at any destination, any rural or non-urban travel, any business related duties or responsibilities and any non-hotel travel accommodations:			

AVOCATION INFORMATION			
Have you ever participated, or do you intend to participate, in any of these activities? (Please check those that apply, and complete the related questionnaire: <b>A- Aviation, C-Mountain Climbing, D- Diving, G- General Avocation, R- Racing.</b> )			
<input type="checkbox"/> auto racing (R)	<input type="checkbox"/> climbing or mountaineering (C)	<input type="checkbox"/> motorcycle racing (R)	<input type="checkbox"/> ultralight flying (G)
<input type="checkbox"/> ballooning (G)	<input type="checkbox"/> flying (private aviation) (A)	<input type="checkbox"/> parachuting, sky diving and sky surfing (G)	<input type="checkbox"/> any type of extreme sport or hazardous activity not listed (G)
<input type="checkbox"/> boat racing (R)	<input type="checkbox"/> gliding (sailplaning, soaring) (A)	<input type="checkbox"/> paragliding (G)	
<input type="checkbox"/> cave exploring (G)	<input type="checkbox"/> hang gliding (G)	<input type="checkbox"/> scuba diving (D)	

## Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **GBS Insurance and Financial Services, Inc.** (the “Representative”) and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of the next page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. 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, prescription drug records and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature on the next page, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of the next page and their reinsurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date signed. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative at 21600 Oxnard Street, Suite 650, Woodland Hills, CA 91367 to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed

below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

<b>Proposed Insured's Name</b>		<b>Proposed Insured's Signature</b>
<b>Date of Birth</b>	<b>Signed and Dated On</b>	<b>At (City, State, Zip Code)</b>

**Agent/Witness Signature:** \_\_\_\_\_

**Print Agent/Witness Name:** \_\_\_\_\_

**AUTHORIZED RECIPIENTS**

Accordia Life and Annuity Company	John Hancock	Pan-American Life Insurance Group
Allianz Life Insurance Company of North America	Illinois Mutual Life Insurance Company	Penn Mutual Life
American General Life Insurance Company	Dr. Charlotte Lee	Penn Treaty Network America Insurance Company
American Memorial Life Insurance Company	Life Insurance Company of the Southwest	Peterson International Underwriters
American National Insurance Companies	LifeCare Assurance Company	Principal Life Insurance
Ameritas Life Insurance Company	LifeSecure Insurance Company	Principal National Life
Assurity Life Insurance Company	Lincoln Financial Group	Protective Life
AXA/Equitable	Mass Mutual	Pruco Life Insurance Company
Banner Life Insurance Company	Melville Capital LLC	Pruco Life Insurance Company of New Jersey
Berkshire Life Insurance Company	Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates	Prudential Insurance Company of America
BrightHouse Life Insurance Company	Minnesota Life	ReliaStar Life Insurance Company
BrightHouse Life Insurance Company of NY	Mutual of Omaha Insurance Companies	ReliaStar Life Insurance Company of New York
Cincinnati Life	Mutual Trust Life Insurance Company	The Savings Bank Life Insurance of Massachusetts
Companion Life Insurance Company	National Guardian Life	Security Life of Denver Insurance Company
dibrokerWest	National Life	Standard Insurance Company
Diversified Brokerage Services (DBS)	Nationwide Life Insurance Company	State Life
Exceptional Risk Advisors	Nationwide Life and Annuity Insurance Company	The State Life Insurance Company
Fidelity and Guarantee	New York Life	Symetra Life Insurance Company
Fidelity Security Life Insurance Company	North American for Life and Health	Transamerica Insurance & Investment Group
Focus 10 Life, Inc.	OneAmerica Financial Partners, Inc.	United of Omaha Life Insurance Company
Forethought Life Insurance Company	Pacific Life Insurance Company	United States Life Insurance Company in the City of New York
Genworth Financial Family of Companies	Pan-American Assurance Company	Voya Insurance and Annuity Company
Global Atlantic Financial Group	Pan-American Assurance Company International, Inc.	Western National
Great Western Insurance Company	Pan-American Life Insurance Company	William Penn Life Insurance Company of New York
The Guardian Life Insurance Company of America		
HCC Specialty		