GBS Insurance and Financial Services
A Gallagher Company

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

Producer Name:			**Date:**
Client Name: First Middle Initial Last		☐ Male ☐ Female	SSN
Date of Birth	Citizenship	Driver's License Info: State:	#
Present Address:	City:	State:	Zip:
Proposed Amount of Insurance:	Purpose of Insurance: ☐ Personal ☐ Business	Plan: ☐ Term ☐ Universal Life ☐ Whole Life ☐ Survivorship	Type: ☐ Fixed ☐ Index ☐ 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? ☐ Yes ☐ No

If yes, which policies?

Do you have any other pending (or anticipated) applications for life insurance? ☐ Yes ☐ No

If yes, please provide insurance company name, face amount, date of application:

Have you had a life insurance application declined, rated, postponed, withdrawn, modified, canceled, or not renewed? ☐ Yes ☐ No

If yes, list date and reason:

TOBACCO USE

Have you ever used any form of tobacco or nicotine products? ☐ Yes ☐ No

If yes, type and quantity used ☐ Cigarettes ☐ Cigars/Cigarillos ☐ Pipe ☐ Smokeless

☐ Nicotine delivery systems (including gums, inhalers, lozenges, patches, wafers, etc.)

If yes, are you a current user? ☐ Yes ☐ No use If no, date of last use:

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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?

☐ Heart Disease (incl. coronary artery disease, chest pain or angina, heart attack, heart enlargement, murmur, valve problem, etc.)

☐ Lung Disease (incl. asthma, emphysema, bronchitis, etc.) ☐ Cancer (including melanoma) ☐ Stroke ☐ Diabetes Mellitus

☐ Dementia or Memory Loss ☐ Hepatitis B or C ☐ Reduced Kidney Function ☐ High Cholesterol ☐ High Blood Pressure

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

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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? ☐ Yes ☐ No
2. Used any non-prescription controlled substances, including cocaine, marijuana, heroin, amphetamines, barbiturates, etc.? ☐ Yes ☐ No
3. Had a prescription for marijuana? ☐ Yes ☐ No If yes, please provide details:

Type of drug(s)/alcohol products(s):	Date last used:

Frequency of use: ☐ Daily ☐ Weekly ☐ 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? ☐ Yes ☐ 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:			☐ Yes ☐ No Age of Onset:	☐ Yes ☐ No Age of Onset:	
Mother:			☐ Yes ☐ No Age of Onset:	☐ Yes ☐ No Age of Onset:	
Sister(s):			☐ Yes ☐ No Age of Onset:	☐ Yes ☐ No Age of Onset:	
Brother(s):			☐ Yes ☐ No Age of Onset:	☐ Yes ☐ No Age of Onset:	

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FOREIGN TRAVEL OR RESIDENCE

Is foreign **travel** or **residence** contemplated within the next two (2) years? ☐ Yes ☐ 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: **A - Aviation, C - Mountain Climbing, D - Diving, G - General Avocation, R - Racing**)

- ☐ auto racing (R)
- ☐ ballooning (G)
- ☐ boat racing (R)
- ☐ cave exploring (G)
- ☐ climbing or mountaineering (C)
- ☐ flying (private aviation) (A)
- ☐ gliding (sailplaning, soaring) (A)
- ☐ hang gliding (G)
- ☐ motorcycle racing (R)
- ☐ parachuting, sky dividing and sky surfing (G)
- ☐ paragliding (G)
- ☐ scuba diving (D)
- ☐ ultralight flying (G)
- ☐ any type of extreme sport or hazardous activity not listed (G)

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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 21820 Burbank Boulevard, Suite 301, 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.

Proposed Insured's Name _____ **Proposed Insured's Signature** _____

Date of Birth _____ **Signed and Dated On** _____ **At (City, State, Zip Code)** _____

Agent/Witness Signature: _____

Print Agent/Witness Name: _____

AUTHORIZED RECIPIENTS

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