



Informal Underwriting Inquiry

Details of Previous Applications or Inquiries to Other Companies

Full Name		Plan of Insurance WL UL Term ____ Years	Face Amount \$
Date of Birth	Birth State/Country	Planned Premium \$	
Resident Address		Beneficiary (name & relationship)	
Male ____ Female ____	Height _____ Weight _____	Do you use tobacco in any form? What Type? Yes ____ No ____	
Social Security Number		What is your occupation? What are your specific daily activities?	
Driver's License Number State Any moving violations in the past 3 years?		How much In Force coverage? Company Amount of Insurance Year Issued _____	

Medical History

Doctor/Hospital: Name, Address & Phone	Dates Seen & Reason for Visit	Treatment & Results
1.		
2.		
3.		

In Force or Pending Coverage

Carrier Name	Face Amount	Underwriting Decision
	\$	
	\$	
	\$	
	\$	

Family History

Family Health History	Age (If deceased, age at death)	History of Heart Disease	History of Cancer (All Types)
Mother			
Father			
Sister(s)			
Brother(s)			

American General/US Life
Allianz
Allstate NY
American National Life
Assurity Life
AVIVA/AVIVA NY
AXA
Banner Life
Companion Life

Fidelity Life
First MetLife Investors-NY
Genworth Life & Annuity
Genworth Life of NY
Hartford Life & Annuity
Hartford Life Ins Co. NY
Illinois Mutual Life
ING Reliastar
ING-Reliastar Life of NY

John Hancock Life
John Hancock USA/NY
Lafayette Life
Lincoln Benefit Life
Lincoln National Life
Lincoln Life & Ann of NY
Metropolitan Life
Met Life Investors
Minnesota Life

Mutual of Omaha
Nationwide
North American
Petersen International
Presidential Life
Principal Life
Prudential Life
Security Life of Denver
Symetra

Transamerica Life
Transamerica Financial
Union Central Life
United of Omaha Life
West Coast Life

Please answer the following questions that apply to your medical history. Please put as much detail as possible in the Remarks and Details space to the right.

GENERAL INFORMATION

(If not already on the front of the form)

1. Please supply us with the name and address of your current primary attending physician:
2. Please supply a complete list of all medications or prescriptions that you are currently taking:

DIABETES

3. If you have been diagnosed with or treated for Diabetes:
 - a. Indicate to the right how your diabetes is controlled: diet alone, name of oral medication or insulin. If insulin is used, show the total number of insulin units used per day.
 - b. Have you had any complications as a direct result of your diabetes such as vision problems, diabetic coma, insulin shock, high blood pressure kidney problems, or heart disease?

HEART DISEASE

4. If you have experienced a heart attack, chest pain, or angina:
 - a. When was the first time? Most recent occurrence?
 - b. Are you taking any heart medication? If so, what type and what dosage?
 - c. Have you had bypass surgery? When and where?
 - d. Have you had angioplasty performed?
 - e. Who is your current physician for your heart disease?

CANCER

5. If you have been treated for cancer, for any malignancy or for any skin growths:
 - a. Please indicate the location of the growth
 - b. Was any surgery performed, when and where?
 - c. Have you had any radiation or chemotherapy?
 - d. Who is your oncologist?

HIGH BLOOD PRESSURE

6. If you have been diagnosed with High Blood Pressure:
 - a. What medication are you currently taking?
 - b. What was your last reading and when?

DRUG & ALCOHOL HISTORY

7. If you have ever been treated for excessive use of alcohol or abuse of drugs, controlled substances or prescription medication:
 - a. Please provide complete dates of treatments, the name and location of treatment facility, and the names of any doctors seen in connection to this
 - b. When was the last time you used alcohol or drugs? Are you currently using any of the above?
 - c. Do you have any DUI/DWI's on your motor vehicle report?

Foreign Travel & Hobbies

8. Have you previously or do you currently have plans to travel outside of the US?
 - a. Where?
 - b. When?
 - c. How Long?
 - d. How Often?
 - e. Reason?
 - f. Next Scheduled Trip?
9. Do you participate in any hazardous activities or hobbies? If so, what?

Other

10. List any medical conditions and treatments not listed above

REMARKS & DETAILS:

Disclosures

The preceding page is an authorization which complies fully with the HIPAA privacy rules which went into effect on April 14, 2003. Medical offices are requiring an authorization signed by the individual requesting the release of medical records for insurance underwriting purposes. Some medical providers even require an original signed authorization before they will release medical records. So, to make sure your client's informal inquiry goes through smoothly, we request that you:

1. **Make a copy of this HIPAA Authorization page.**
2. **If your client names one attending physician, send us two originally signed authorizations.**
3. **If your client names four attending physicians, send us five originally signed authorizations.**
4. **You can FAX us the inquiry form and one HIPAA authorization so we can start on your client's case, but please be sure to mail us the original HIPAA Authorization(s) you have collected.**

Notice of Information Practices

During the process of underwriting your client's insurance coverage, the listed insurance companies will rely heavily on information provided by your client. The companies may also seek information from others, such as medical professionals who have treated them. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your client's specific authorization. Your client has the right to receive in writing the items of personal information which appear in the insurance companies' files, including information contained in investigative reports. They also have the right to seek corrections to information they believe to be inaccurate.

The above is a brief description of information practices of **The Ark Group** and the above listed companies. If you would like to receive a more detailed explanation of these practices, please send your request to your agent who will facilitate the request.

Notice to Proposed Insured

In connection with your informal inquiry about 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 includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested and, if so, you will be advised of the name and address of the consumer reporting agency to which the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You will have the right to inspect a copy of any such report, by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice, or their reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim of benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone: (617) 426-3660. The companies listed in this Notice or their reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.



Authorization for Release and Disclosure of Health Information
(This Authorization Form Is In Compliance With All HIPAA Privacy Rules and Regulations)

I hereby authorize any Critical Illness, Disability, Life, Health, Long-Term Care and Annuity insurance company, their Re-Insurers, insurance support organizations such as Medical Information Bureau, Inc. and/or consumer reporting agencies, health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility or other health care provider that has provided payment, treatment or services to me or on my behalf (herein referred to as "My Providers") to disclose my entire medical record and any other protected health information concerning me to The Ark Group, its employees and those persons or entities providing services to The Ark Group. This includes but is not limited to information on the diagnosis or treatment of: Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, mental illness (psychotherapy notes excluded), the use of alcohol, drugs and/or tobacco.

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 further instruct my providers to release and disclose my entire medical record without restriction.

This protected health information shall be disclosed under this authorization so that The Ark Group may:

1. Assist in the underwriting of my application for coverage, including eligibility, risk rating, policy issuance and enrollment determinations;
2. Assist in obtaining reinsurance consideration;
3. Conduct other legally permissible activities that relate to any coverage I have or have or may applied for.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request to: The Ark Group, 1055 N. 115th St., Suite 200, Omaha, Nebraska, 68154. I further understand that a written revocation is not effective to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any information disclosed pursuant to their authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand and accept 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 records, The Ark Group may not be able to process my application properly. I acknowledge that I will receive a copy of this authorization upon my request.

Printed Name of Proposed Insured

Date of Birth

Signature of Proposed Insured

Date

Description of Representative Agent's Authority/Relationship to Proposed Insured

Printed Name of Agent

Signature of Agent