



Preliminary Inquiry - Not an application for life insurance

**Personal History**

Name \_\_\_\_\_ Male / Female Social Security \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Monthly Earned Income \_\_\_\_\_

Occupation \_\_\_\_\_

**Plan of Insurance applied for - must be completed**  
**Minimum Consideration: 1,000,000 of term: \$500,000 of perm and/or minimum premium**

Universal Life Whole Life Term Level Period \_\_\_\_\_ Survivorship\*  
 Date of last nicotine use: \_\_\_\_\_ Specify Tobacco: \_\_\_\_\_ Using Nicotine Gum or Patch? \_\_\_\_\_  
 Face amount desired: \_\_\_\_\_ Premium amount desired: Annual \_\_\_\_\_ Monthly \_\_\_\_\_

What is the purpose for the insurance? \_\_\_\_\_  
 \*If both have insurability questions, complete this form on each.

**What adverse action or table rating was offered by another company?**

Did your primary company work this case? Yes / No

Company	Date	Amount	Action	Current Premium	Total

Is another Special Risk Agency considering this case? Yes / No

**Other Insurance on Proposed Insured**

Total amount in force \_\_\_\_\_ Date of last application \_\_\_\_\_ Are you replacing Yes / No

Name of Company \_\_\_\_\_

**Agent information**

Name \_\_\_\_\_ SS# \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Fax No. \_\_\_\_\_

**Inquiry cannot be considered unless authorization is signed by Proposed Insured**

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I, \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ ("Patient" or "Insured"), hereby authorize any physician, doctor, nurse, physician practice group, medical practitioner, pharmacy, hospice, hospital, clinic or other medical or medically related facility or health care provider, insurance support organization, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, "Authorized Discloser", hereafter referred to as, "AD"), to provide to American Brokerage Services, Inc. and/or its authorized representatives, affiliates, directors, officers, employees, agents, independent contractors, and service providers including medical review services, LLC (collectively, "ABS"), any and all information as to diagnosis, treatment, and prognosis with respect to any physical or mental condition including psychiatric conditions, HIV and/or AIDS, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, x-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I specifically authorize my insurance organizations or support organizations to release any life insurance policy or certificate information, including but not limited to, applications for insurance, forms, riders, illustrations, conversions, and amendments concerning the policy or certificate, and any other general information requested by ABS about my coverage.

I understand that the ABS will treat all information disclosed hereunder as confidential and use the same level of care it uses with its own confidential information. ABS will only use the information for the purpose of obtaining life insurance quotes, a life insurance settlement or a related purpose. Furthermore, ABS will not release any confidential information to any person or organization except as permitted hereunder, as may be otherwise lawfully required or as I may further authorize. I understand that this transaction requires ABS to re-disclose the information to necessary third parties in order to complete the transaction, which may render it no longer protected under HIPAA privacy laws. I may revoke this Authorization at any time with respect to any AD by notifying such AD of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such AD. Any revocation shall not apply to the extent that the AD has taken action in reliance upon this Authorization prior to receiving notice of my revocation.

I specifically authorize and request my insurance company and each AD to rely upon a photographic copy or facsimile copy or other reproduction of this Authorization. I am executing and delivering this Authorization freely and voluntarily as of the date written below. I have a full understanding of the Authorization's contents and I will retain a completed copy for future reference. I agree that this Authorization shall remain valid until and will expire on the date of my death or until the case is declined, absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted by such law.

Signed at \_\_\_\_\_ this \_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_\_

Signature of Proposed Insured

X \_\_\_\_\_



**Please provide full medical history on page 2**

Medical History - This section must be fully complete	Date	Illness
1. Who is your personal physician? Doctors name, Address and phone # When did you last consult him/her?		
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations.)		
3. In what clinics, hospital, or sanitariums have you ever been treated?		
4. Please list all current medications		

*Please be specific with the above information and include phone numbers. It will expedite processing. It is also helpful to know who has results of any special tests.*

**5. Family Health History**

	Age (If diseased)	Age (If Living)	History of Heart Disease or Circulatory Disorder		History of Cancer, all types	
			Yes	No	Yes	No
Mother	_____	_____				
Father	_____	_____				
Sister(s)	_____	_____				
Brothers	_____	_____				

**Drug and Alcohol Usage Questionnaire - If applicable**

**1. Do you presently use alcoholic Beverages? Yes / No**

If "No", approximate date of last drink: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Quantity: Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_  
 Daily \_\_\_\_\_

**2. Did you ever drink substantially more than at present? Yes / No**

If "yes", when? From : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ to: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Quantity: Beer \_\_\_\_\_ Wine \_\_\_\_\_ Liquor \_\_\_\_\_  
 Daily \_\_\_\_\_

**3. Are you active and attending meetings in AA or other recovery groups?**  
 Yes / No How long? \_\_\_\_\_

**4. Because of your alcohol use, have you ever consulted a doctor or received treatment? Yes / No**

**5. Have you ever been arrested for driving under the influence of alcohol? Yes / No**  
 If "Yes", give details and driver license number \_\_\_\_\_

**6. Have you ever sought medical treatment because of drug usage or has drug usage ever been a problem? Yes / No**

**7. Date of last drug use \_\_\_\_\_**  
**Type of drug used \_\_\_\_\_**

*This preliminary inquiry is used exclusively to gather specific information on a proposed insured's medical history and other factors that may contribute to a sub-standard underwriting classification. It is not a formal application for insurance and in no way guarantees a specific underwriting class or binds insurance coverage for the proposed insured*