



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

**Personal History - (this section must be completed)**

Name \_\_\_\_\_  Male  Female Soc. Sec. # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Monthly Earned Income \$ \_\_\_\_\_  
 Occupation \_\_\_\_\_

**Tobacco/Nicotine Usage**

1. Have you ever smoked cigarettes: Y / N if yes, date of last usage: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
2. Have you used other tobacco or nicotine containing products: Y / N (examples: cigars, pipe, snuff, nicotine gum or patch)  
 If yes, provide types and last date of use:

\_\_\_\_\_  
 \_\_\_\_\_

**Agent Information - (this section must be completed)**

Name \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Phone No. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax No. \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Requested Plan of Insurance - (this section must be completed)**

Universal Life  Variable Life  Whole Life  Term, Level Period \_\_\_\_\_  Survivorship\*  Other \_\_\_\_\_  
 Face amount desired: \_\_\_\_\_ Premium amount desired: \_\_\_\_\_  Annually  Monthly  
 What will be the purpose of the insurance? \_\_\_\_\_

**Provide details on pending and in-force coverage:**

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?
					Y / N
					Y / N
					Y / N
					Y / N

**Medical History - (this section must be completed)**

1. Who is your primary care physician? When did you last consult him/her?	Doctor's name, address, and phone number	Date	Illness
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations.)			



Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**Medical History** (continued) - (this section must be completed)

3. In what hospitals, clinics, or other health facilities have you ever been treated?

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4. Please list all current medications.

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**Family History** -  check here if this section is not applicable

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Y / N  
If yes, please provide the following details:

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

**Drug and Alcohol Usage Questionnaire** -  check here if this section is not applicable

Do you currently drink alcohol? Y / N Date of last consumption: _____ Note amount below.	Did you ever drink substantially more than present? Y / N If yes, when? _____ Note amount below.
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Type:	Amount per week:	Type:	Amount per week:
Beer		Beer	
Wine		Wine	
Liquor		Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use? Y / N  
 Have you ever been arrested for driving under the influence of alcohol? Y / N  
 If yes, provide date(s): \_\_\_\_\_  
 \_\_\_\_\_

Have you ever sought medical treatment because of drug use or has drug use ever been a problem? Y / N  
 If yes, provide details:  
 Types of drug(s) used: \_\_\_\_\_  
 Date of last use: \_\_\_\_\_



Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**Coronary -  check here if this section is not applicable**

- 1. Date of diagnosis or first chest pain: \_\_\_\_ - \_\_\_\_ - \_\_\_\_
- 2. Number of diseased vessels: \_\_\_\_\_
- 3. Dates/details of treatment/surgery (examples: Angioplasty, Bypass)  
\_\_\_\_\_  
\_\_\_\_\_
- 4. Date of last stress EKG: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Results: \_\_\_\_\_  
By whom? \_\_\_\_\_
- 5. Any pain since treatment/surgery? \_\_\_\_\_

**Cancer -  check here if this section is not applicable**

- 1. Exact name and location of cancer: \_\_\_\_\_
- 2. Stage and grade: \_\_\_\_\_
- 3. Who would have the pathology report? \_\_\_\_\_
- 4. Dates/details of treatment/surgery: \_\_\_\_\_

**Diabetes -  check here if this section is not applicable**

- 1. Date of diagnosis: \_\_\_\_ - \_\_\_\_ - \_\_\_\_
- 2. Treatment: (circle one)      Diet Only      Oral Medication      Insulin  
Details: \_\_\_\_\_
- 3. Do you regularly test your blood glucose? Y / N  
Results: \_\_\_\_\_ Frequency: \_\_\_\_\_
- 4. Latest result of glycohemoglobin (A1C) test: \_\_\_\_\_ mg%  
Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_
- 5. Have you been diagnosed with having protein and/or microalbumin in your urine? Y / N
- 6. Have you EVER had:
 

a. any eye trouble?	Y / N	d. kidney trouble?	Y / N
b. heart trouble?	Y / N	e. neuritis/neuralgia?	Y / N
c. high blood pressure?	Y / N	f. insulin reactions?	Y / N

**Hazardous Activities -  check here if this section is not applicable**

Are you a private pilot? Y / N If yes, provide details below.  
 How many total hours have you flown as Pilot in Command? \_\_\_\_\_  
 How many hours do you fly per year? \_\_\_\_\_  
 Do you have an IFR (instrument flight rating)? Y / N

Do you participate in the following activities? (circle those that apply)

Scuba Diving	Bungee Jumping	Ultralight Flying	Sky Diving
Mountain Climbing	Hang Gliding	Auto/Motorcycle Racing	



**Authorization for Release of Information**

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Tennessee Brokerage Agency and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

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 my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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 and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, 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 Tennessee Brokerage Agency. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed 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 below and their re-insurers as well as Tennessee Brokerage Agency and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. 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 my Representative to revoke this authorization and that the revocation will take effect when my 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 understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Tennessee Brokerage Agency 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 Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

\_\_\_\_\_  
**Proposed Insured's Name**

\_\_\_\_\_  
**Proposed Insured's Signature**

\_\_\_\_\_  
**Signed and Dated On**

\_\_\_\_\_  
**At (City, State, Zip Code)**

\_\_\_\_\_  
**Agent/ Witness**

AIG, American General Life Insurance Company, American National Insurance Companies, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, ING USA Annuity and Life Insurance Company, John Hancock, Lincoln Benefit Life, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Security Life of Denver Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, West Coast Life Insurance Company