6508 Baum Dr.
Knoxville, TN
865-588-9555
800-624-4502

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)

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

All pagesmust be completed.

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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?		
4. Please list all current medications.		

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.

Type:	Amount per week:
Beer	
Wine	
Liquor	

Did you ever drink substantially more than present? ○Y / N○
If yes, when? _____
Note amount below.

Type:	Amount per week:
Beer	
Wine	
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: _____

All pages must be completed.

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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 ○

All pages must be completed.

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