# PRELIMINARY INSURANCE EVALUATION

THIS "PRELIMINARY INSURANCE EVALUATION" is a request to the various Insurance Companies and organizations listed on the enclosed authorization to obtain and disclose information. By completing the questions you will have an opportunity to receive the best program available for your insurance needs at the lowest cost possible. An in-depth search of the marketplace will be made on your behalf without the necessity of taking a preliminary medical examination. The various quotes will be analyzed and compared by Brokerage Professionals, Inc. and the best plans will be forwarded to your Insurance Professional for your consideration. All information gathered for our companies will be held in the strictest confidence.

There is no need to be discouraged by a rating on an existing policy or application for insurance as there are many companies using a more enlightened approach to medically impaired situations. With the constant improvements in medical treatment, underwriting by our insurance companies has been more and more favorable to our clients. This same trend has been reflected in the consideration of risks for occupations such as pilots and miners or hobbies like scuba diving or hang gliding. With our many guaranteed issue plans available almost everyone is insurable!

Please take a few minutes to complete this **"PRELIMINARY INSURANCE EVALUATION"** and discover for yourself the outstanding solutions for your insurance needs.

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**PRELIMINARY INSURANCE EVALUATION**
NOT AN APPLICATION FOR LIFE INSURANCE
DO NOT SUBMIT UNLESS DEATH BENEFIT
IS $100,000 OR MORE

## PERSONAL HISTORY

| FULL NAME | DATE OF BIRTH | ☐ MALE ☐ FEMALE |
|---|---|---|
| ADDRESS | CITY | STATE | ZIP |

| SOCIAL SECURITY NUMBER | HEIGHT | WEIGHT | OCCUPATION & DUTIES |
|---|---|---|---|
| NET WORTH | | | |
| ANNUAL INCOME | | | |

## TOBACCO USAGE

ARE YOU NOW A CIGARETTE SMOKER? ☐ YES ☐ NO

HOW MUCH DO YOU SMOKE? ☐ LESS THAN 2 PACKS/DAY ☐ 2 PACKS OR MORE/DAY

HOW LONG HAVE YOU SMOKED CIGARETTES?______________________________________________

IF YOU HAVE EVER SMOKED CIGARETTES AND STOPPED,
WHAT WAS THE DATE YOU LAST SMOKED?__________________________MONTH __________________YEAR ________________

DO YOU USE TOBACCO IN ANY OTHER FORM? (INCLUDING PIPE, CIGARS, CHEW, SNUFF, NICORETTE GUM, NICOTINE PATCH, ETC.)

☐ YES IF YES PLEASE PROVIDE DETAILS:________________________________________________________________________

☐ NO ______________________________________________________________________________________________

## REQUESTED PLAN OF INSURANCE

| AMOUNT OF INSURANCE | ☐ TERM ☐ UNIVERSAL LIFE ☐ WHOLE LIFE ☐ 2ND TO DIE | |
|---|---|---|
| ACCEPTABLE PREMIUM<br>$ ______________________ | BENEFICIARY | RELATIONSHIP |
| | PURPOSE OF INSURANCE | |

## OTHER INSURANCE ON PROPOSED INSURED

| TOTAL AMOUNT IN FORCE | DATE OF LAST APPLICATION | IS INSURANCE APPLIED FOR TO REPLACE EXISTING INSURANCE? ☐ YES ☐ NO |
|---|---|---|
| NAME OF COMPANY | 1035 AMOUNT | CURRENT PREMIUM |

## WHAT ADVERSE ACTION OR TABLE RATING WAS OFFERED BY OTHER COMPANIES?

| COMPANY | DATE | AMOUNT | ACTION | PREMIUM OFFERED |
|---|---|---|---|---|
| | | | | |
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## MEDICAL HISTORY

| PERSONAL PHYSICIAN | PHONE | SPECIAL CLINIC NUMBER | |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |

DATE AND REASON FOR LAST CONSULTATION

WHAT TREATMENT WAS GIVEN OR MEDICATION PRESCRIBED?

HAVE YOU WITHIN THE PAST 10 YEARS:

1. BEEN DIAGNOSED OR TREATED BY A MEDICAL PROFESSIONAL FOR ANY MENTAL OR PHYSICAL DISORDER? ☐ YES ☐ NO
2. HAD A CHECKUP, CONSULTATION, ILLNESS INJURY, SURGERY, OR RECEIVED ANY MEDICAL ADVICE? ☐ YES ☐ NO
3. BEEN A PATIENT IN A HOSPITAL, CLINIC, SANITARIUM, OR OTHER MEDICAL FACILITY? ☐ YES ☐ NO
4. HAD AN ELECTROCARDIOGRAM, EKG,STRESS EKG, X-RAY, OR OTHER DIAGNOSTIC TEST? ☐ YES ☐ NO
5. BEEN ADVISED BY A MEDICAL PROFESSIONAL TO HAVE ANY DIAGNOSTIC TEST, HOSPITALIZATION, OR SURGERY WHICH HAS NOT BEEN COMPLETED? ☐ YES ☐ NO

**IF YOU ANSWERED YES TO ANY OF THE ABOVE OR COMPLETED ANY OF THE HEALTH QUESTIONNAIRES ON PAGE 4, THE FOLLOWING SECTION MUST BE COMPLETED – IT IS IMPORTANT TO PROVIDE THE COMPLETE NAME, ADDRESS, AND PHONE NUMBERS OF ANY DOCTORS, HOSPITALS OR OTHER MEDICAL FACILITIES. PLEASE ANSWER COMPLETELY AND COMPREHENSIVELY!**

| QUEST | DATE | DETAILS OR NAME OF QUESTIONNAIRE | DOCTOR'S NAME & ADDRESS | PHONE |
|---|---|---|---|---|
| | | | | |
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## SPORTS AND AVOCATIONS STATEMENT

1. DO YOU, OR DO YOU INTEND TO FLY AS A PILOT, STUDENT PILOT OR CREW MEMBER? ☐ YES ☐ NO
2. DO YOU NOW, OR DO YOU INTEND TO PARTICIPATE IN AUTOMOBILE, MOTORBOAT, OR MOTORCYCLE RACING, SKYDIVING, HANG-GLIDING, SKIN OR SCUBA DIVING? ☐ YES ☐ NO
3. DO YOU INTEND TO CHANGE YOUR RESIDENCE OR TRAVEL OUTSIDE THE U.S. OR CANADA? ☐ YES ☐ NO

(IF YES COMPLETE APPROPRIATE QUESTIONNAIRE – ANY COMPANIES FORM WILL SUFFICE)

## AGENT INFORMATION AND REPORT

| NAME | SOCIAL SECURITY NUMBER | PHONE | FAX PHONE |
|---|---|---|---|
| ADDRESS | CITY | STATE | ZIP |

DID YOUR PRIMARY COMPANY OFFER ON THIS CASE? ☐ YES ☐ NO

RATING

LIST ALL COMPANIES & OTHER IMPAIRED RISK AGENCIES CURRENTLY REVIEWING FILE

## SIGNATURES REQUIRED

SIGNATURE OF AGENT DATE

SIGNATURE OF APPLICANT DATE

# THE APPROPRIATE QUESTIONNAIRE MUST BE COMPLETED!

## BLOOD PRESSURE QUESTIONNAIRE

| NAME OF BLOOD PRESSURE MEDICATIONS | AVERAGE BLOOD PRESSURE READING | HIGHEST BLOOD PRESSURE READING |
|---|---|---|

## CHEST PAIN – CORONARY QUESTIONNAIRE

HAS ANY PHYSICIAN SAID YOU HAD OR HAVE:

1 HEART DISEASE ☐ YES ☐ NO
2 HEART ATTACK ☐ YES ☐ NO
3 MYOCARDINAL INFARCTION ☐ YES ☐ NO
4 ANGINA ☐ YES ☐ NO
5 CORONARY ARTERY DISEASE ☐ YES ☐ NO
6 ENLARGED HEART ☐ YES ☐ NO
7 CARDIOMYOPATHY ☐ YES ☐ NO
8 CONGESTIVE HEART FAILURE ☐ YES ☐ NO
9 ARRHYTHMIA ☐ YES ☐ NO

HAVE YOU EVER HAD OR BEEN ADVISED TO HAVE HEART SURGERY, CORONARY ARTERY BYPASS, ANGIOPLASTY OR VALVE REPLACEMENT?

LOCATION & TYPE OF VALVE USED?

DATE OF PROCEDURE

NUMBER OF VESSELS INVOLVED?

HAVE YOU EVER HAD A

1 HEART CATHETERIZATION ☐ YES ☐ NO
2 ANGIOGRAPHY ☐ YES ☐ NO
3 THALLUIM SCAN ☐ YES ☐ NO

OBSTRUCTION PERCENTAGE

PLEASE LIST ALL MEDICATIONS INCLUDING DOSAGE:

| IS YOUR CURRENT RESTING EKG NORMAL? | DATE OF LAST RESTING EKG | WAS YOUR LAST STRESS EKG NORMAL? | DATE OF LAST STRESS EKG |
|---|---|---|---|

## CANCER QUESTIONNAIRE

| LOCATION OF CANCER | SURGERY DATE | EXACT NAME OF CANCER (SARCOMA, CARCINOMA, EPITHELOMA, ETC.) |
|---|---|---|

| NUMBER OF ADJACENT LYMPH NODES WITH ABNORMAL CELLS | ANY RADIATION OR CHEMOTHERAPY? | DATE OF LAST TREATMENT |
|---|---|---|

| HAS THERE BEEN ANY REOCCURENCE OF CANCER? | IF SKIN CANCER, WAS IT MELANOMA? | CLARKS LEVEL RATING | TUMOR GRADE |
|---|---|---|---|

## DIABETES QUESTIONNAIRE

| DATE OF DIAGNOSIS | DO YOU REGULARLY TEST YOUR BLOOD SUGAR? | RESULTS | DATE LAST TESTED | LAST GLYCOHEMOGLOBIN TEST READING AND RATE |
|---|---|---|---|---|

TREATMENT: ☐ DIET ONLY ☐ ORAL MEDS ☐ INSULIN

NAME: DOSAGE:

TYPE: NUMBER OF UNITS:

HAVE YOU EVER HAD:

1 ANY EYE TROUBLE ☐YES ☐ NO
2 HEART TROUBLE ☐YES ☐ NO
3 HIGH BLOOD PRESSURE ☐YES ☐ NO
4 KIDNEY TROUBLE ☐YES ☐ NO
5 NEURITIS/NEURALGIA ☐YES ☐ NO
6 INSULIN REACTIONS ☐YES ☐ NO

## DRUG AND ALCOHOL USAGE QUESTIONNAIRE

| DO YOU PRESENTLY USE ALCOHOLIC BEVERAGES? | DATE OF LAST ALCOHOLIC BEVERAGE | NAME OF SUPPORT GROUP | HOW LONG |
|---|---|---|---|

| IF YOU HAVE BEEN ARRESTED FOR DRIVING UNDER THE INFLUENCE OF ALCOHOL OR DRUGS, PLEASE INCLUDE DETAILS, DATE, STATE OF ARREST, AND DRIVERS LICENSE NUMBER: | DID YOU HAVE ELEVATED LIVER ENZYMES WHEN DRINKING? |
|---|---|

# AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
## This Authorization complies with the HIPAA Privacy Rule

**Proposed Insured:** _____________________________________________ **Date of Birth**____________________

**Address**_____________________________________________**Social Security #**__________________________

**To (Doctor/Facility):**_______________________________________**Medical Record #**_____________________

Advantage Insurance Network
AIG
Allstate Life of New York
American General
American National
Ameritas
Athene
APPS
APS Workflow, Inc.
Assurity
Aviva
AXA
Banner Life
Brokerage Professionals, Inc.
Cincinnati Life
CMS
Columbus Life Ins. Co.
Companion Life
DIS
EMSI
Exam One
First Insurance Funding
Foresters
Genworth
Genworth Life Ins. Co of New York
Guardian
Hartford
Hooper Holmes
HSBC
Integrity Life
JDJ Advisors
Jetstream APS
John Hancock
Kansas City Life
Lafayette Life
Liberty Life
Liberty Mutual
Life Secure
Lincoln Benefit
Lincoln Financial Group
Lincoln Life Ins. Co. of New York
Mass Mutual
Kansas City Life
Metropolitan Life
MetLife Investors
Minnesota Life
Mutual of Omaha
Mutual Trust
National Western Life
Nationwide
National Life
New York Life
NFISCO
NFC Affinity Marketing
One America
Pacific Life
Pan American
Penn Mutual
Portamedic
Premier Financial Concepts,
LLC Principal
Protective Life Inc. Co.
Prudential
Prudential Securities Life
Agency Reliance Standard
ReliaStar Life
ReliaStar of NY
Royal Neighbors
Sagicor
SBLI
Security Life of Denver
Security Mutual Life of NY
Sheila Switzer and
Associates Standard
Insurance
State Life
Succession Capital
Symetra
United of Omaha
United World
Union Central
Voya
Western National
Western Reserve Life
William Penn

______________________________
Other

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any (1) person licensed to provide health care services; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) Medical Information Bureau, Inc., and/or Consumer Reporting Bureau; (7) financial source; (8) employer; (9) any viatical/life settlement provider, including, but not limited to, any of its underwriters, lenders, purchasers of securities and credit enhancers; (10) any life insurance company that has issued a life insurance policy insuring my life, and (11) any of the respective affiliates, agents, employees, representatives, advisors, successors and assigns of any of the persons or entities covered in the immediately foregoing clauses, to furnish the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original. To facilitate rapid submission of such information, I authorize all said sources except Medical Information Bureau, Inc. to give such records or knowledge to **Brokerage Professionals, Inc. 7910 E Thompson Peak Parkway, Suite 101 Scottsdale AZ 85255.**

The types of information will include facts about my: (1) mental and physical health, including, but not limited to, information relating to psychiatric, mental illness, sickle cell anemia, alcohol abuse, drug abuse, prescribed drugs, and HIV-related or communicable disease related diagnosis and treatment if any such information exists; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; and (9) other personal traits; (10) Lab results: (11)Chart notes: (12) EKG tracings; (13) Path reports; (14) All Records for the past 5 years.

The companies named above and their reinsurers will use the information in order to determine whether I am insurable. The insurance agency may also use this information to help update and improve my insurance program.

I understand that once my protected health information is disclosed to others, there is a possibility that it may be redisclosed to individuals or organizations that are not subject to the Health Insurance Portability and Accounting Act (HIPAA) along with other persons who perform business, professional, or insurance tasks for them

This authorization will be valid for twelve (12) months after the date it is signed (two years in Rhode Island). A photocopy of this Authorization is as valid as the original. I acknowledge that I have received a copy of this authorization. I understand that my authorized representative or I may receive a copy of this Authorization. I understand that I have the right to revoke this authorization in writing; except to the extent that ____________________________________ has already taken action in reliance on it; at anytime by sending a written request for revocation to Brokerage Professionals, Inc at 7910 E. Thompson Peak Parkway, Suite 101, Scottsdale AZ 85255. I understand that any revocation will not apply to information that has already been released in response to this authorization.

If a minor child is proposed for coverage, the above statements are made and agreed to by the person authorized to act on the child's behalf.

Signed at ___________________________________________ST______ this _____ day of ______________________, 20____.

Complete if minor child is proposed for coverage:

Name of Child___________________________________

Signature of Minor child,
If required:_____________________________________

_______________________________________________________
Signature of Proposed Insured

_______________________________________________________
Printed Name of Proposed Insured

Verified by Photo ID? Yes_______ No_______

**THIS IS NOT AN APPLICATION FOR INSURANCE**

This is a valid copy

Revised 06/10/2015

Brokerage Professionals, Inc
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www.brokeragepros.com

# PRIVACY POLICY

At Brokerage Professionals, Inc., protecting your privacy is very important to us. We are strongly committed to safeguarding the information you provide us and to using it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

**Collection of Information**

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we received from you on applications, new account forms and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties, including, but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

**Disclosure of Information**

We will not share nonpublic personal information concerning our potential, current, or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third partiers that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your account;
- Your agent or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, such as banks and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information

**Protection of Information**

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Brokerage Professionals, Inc., your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, led or audit functions on our behalf. We maintain physical, electronic, and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.