Informal Application Not an application for life insurance

ALLEGIS ADVISOR GROUP

This Informal Application form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

PERSONAL INFORMATION

Name	Sex ☐ Male ☐ Female	Social Security #
Street Address	City	State Zip

Date of Birth (mm/dd/yyyy)	Age	Height	Weight	Annual Earned Income	Net Worth	Occupation

Foreign National ☐ Yes ☐ No — If yes, list country of citizenship	Traveled outside of the U.S.A. ☐ Yes ☐ No — If yes, list countries visited (also, please complete Foreign Travel Questionnaire)

Green Card ☐ Yes ☐ No	Type of Visa (if applicable)

PRODUCER INFORMATION

Name	Social Security #	Phone #	Email

Street Address City State Zip	Have you submitted this case previously? ☐ Yes ☐ No

CASE GOALS

What is the ultimate goal of this case?	What premium is needed to place the case?

Are you in competition? If so, with what companies?
☐ Yes ☐ No

Where has the case been shopped? Please list the outcome.	If applicable, please list any carriers we should NOT consider

Did you discuss this case with a Sales Associate? ☐ Yes ☐ No	Did you discuss this case with an Underwriter? ☐ Yes ☐ No If yes, list Underwriter(s): _____

Check the following (if applicable)
☐ Business Planning ☐ Estate Planning ☐ Cash Accumulation ☐ Other _____

Is your client interested in the following?
☐ Annuities ☐ Disability Insurance ☐ Long Term Care Insurance

REQUESTED COVERAGE

Select from the following
☐ Universal Life *(Check one: ☐ Guaranteed ☐ Indexed ☐ Variable)* ☐ Survivorship *(Check one: ☐ Guaranteed ☐ Indexed ☐ Variable)*
☐ Whole Life ☐ Term - Level Period: _____

Face amount desired?	Will these premiums be financed? ☐ Yes ☐ No ☐ Possibly	If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? _____

Pending and in-force coverage details:

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

Life Settlements - Indicate any activity in the past five years:

TOBACCO/NICOTINE USAGE

Have you ever smoked cigarettes: ☐ Yes ☐ No If yes, date of last usage:_____	Other tobacco or nicotine products? ☐ Yes ☐ No If yes, list type(s):_____ Date of last usage:_____

MEDICAL HISTORY

Primary Physician's Name	Last consultation (mm/dd/yyyy)	Street Address City State Zip	Phone

List ongoing medical treatment(s)

Doctor's Name	Address	Phone	Date	Illness/Reason

What other physicians have you consulted during the past five years? Why? (exclude insurance examinations)

Doctor's Name	Address	Phone	Date	Illness/Reason

In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities have you ever been treated?

Doctor's Name	Address	Phone	Date	Illness/Reason

List all medications, including over-the-counter drugs and vitamins

FAMILY HISTORY

Have any immediate family members (parents, siblings) been diagnosed or died from cardiovascular disease, cancer, or diabetes?

☐ Yes ☐ No (if yes, provide details below)

Relation (mother, father, brother, sister)	Diagnosis	Approximate Age of disease onset	Living?	Current age or age at death
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

DRUG AND ALCOHOL USAGE QUESTIONNAIRE ☐ Check here if this section is not applicable

Do you currently drink alcohol? If yes, types Date of last consumption Amount per week

☐ Yes ☐ No

Do you ever drink substantially more than present?

☐ Yes ☐ No If yes, when? _____

Have you ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details: _____

Do you currently use marijuana?

☐ Yes ☐ No If yes, type of use (smoked, eaten, etc): _____ Frequency: _____ Medicinal? ☐ Yes ☐ No If yes, list condition: _____

Have you ever used illegal drugs or sought treatment because of drug use?

☐ Yes ☐ No If yes, provide details: _____ Type(s) of drug(s) used: _____ Date of last use: _____

CORONARY ☐ Check here if this section is not applicable

Date of diagnosis or first chest pain (mm/dd/yyyy)	Number of diseased vessels		
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)			
Date of last stress EKG (mm/dd/yyyy)	Results	By whom?	Any pain since treatment/surgery? ☐ Yes ☐ No

CANCER ☐ Check here if this section is not applicable

Exact name and location of cancer	Stage and grade	Who would have the pathology report
Date/details of treatment/surgery		

DIABETES ☐ Check here if this section is not applicable

Date of diagnosis (mm/dd/yyyy)	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details	
Do you regularly test your blood glucose? ☐ Yes ☐ No	Results	Frequency	Latest result of glycohemoglobin (A1C) test mg%_____ Date:_____
Have you been diagnosed with having protein and/or microalbumin in your urine? ☐ Yes ☐ No			

Have you ever had: Eye trouble ☐ Yes ☐ No	Heart trouble ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	Kidney trouble ☐ Yes ☐ No	Neuropathy/Neuralgia ☐ Yes ☐ No	Insulin reactions ☐ Yes ☐ No

HAZARDOUS ACTIVITIES ☐ Check here if this section is not applicable

Are you a private pilot?
☐ Yes ☐ No If yes, If yes, provide details:

Total hours flown as Pilot in Command	How many hours do you fly per year?	Do you have an IFR (instrument flight rating)? ☐ Yes ☐ No

Do you participate in the following activities? (check those that apply)
☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving ☐ Mountain Climbing ☐ Hang Gliding
☐ Auto/Motorcycle Racing ☐ Other: _____

DRIVING HISTORY ☐ Check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any other moving violations in the last 5 years? If yes, explain:

CRIMINAL HISTORY ☐ Check here if this section is not applicable

If yes, please provide details

UNDERWRITING CREDITS

Completing the information below can help us secure the best offer for your client as many carriers can use various crediting options to improve offers.

Complete physical exam by a physician within the past year

Date of Testing (mm/dd/yyyy)	Doctor Name and Contact Information

Executive physical (Mayo, Cooper Clinic, Cleveland Clinic) within the past year

Date of Testing (mm/dd/yyyy)	Doctor Name and Contact Information

Preventative wellness studies within the past two years with normal results

	Date of Testing (mm/dd/yyyy)	Doctor Name and Contact Information
☐ Digital rectal exam		
☐ PSA testing		
☐ Physician skin exam		
☐ Physician testicular exam		
☐ Colonoscopy		
☐ Occult blood in stool testing (stool cards)		
☐ Bone density test		
☐ Mammogram		
☐ Pap smear		
☐ Physician breast exam		

Exercise (list type of exercise, how many times per week and length of each session)

Cardiac testing within the past two years with normal results

	Date of Testing (mm/dd/yyyy)	Doctor Name and Contact Information
☐ Resting EKG		
☐ Treadmill stress test		
☐ Nuclear stress test/stress echocardiogram		
☐ Echocardiogram		
☐ Catheterization or angiogram		
☐ Coronary Calcium Testing (EBCT) with a zero score		

Other testing within the past two years with normal results

	Date of Testing (mm/dd/yyyy)	Doctor Name and Contact Information
☐ Chest CT		
☐ Abdominal CT		
☐ Normal CBC (Complete Blood Count)		
☐ Normal Pulmonary Function Testing/Spirometry		

Older Age (70+)

☐ Driving (distance traveled per week in miles):

☐ Social clubs/groups/volunteer work:

☐ Hobbies:

☐ Travel in the past year:

☐ Does the client handle their own financial affairs/investments:

☐ Does the client work full time, part time, or in consulting:

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The undersigned insured(s) (hereafter referred to as "I", "me" or "my"), authorizes the use and disclosure of my personal health and medical information protected by state and federal law including the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

Description and Purpose of Disclosure: This authorization shall apply to any and all of my personal health and medical information, including medical records in their entirety which may contain mental health records (excluding psychotherapy notes, as defined by HIPAA) and restricted records, life expectancy reports, prescription drug records, HIV-related information, use of alcohol or controlled or prohibited substances, and employment records, whether or not personally or individually identifiable (collectively referred to as my "PHI"). This authorization and all uses and disclosures of my PHI made under this authorization are for the purposes of allowing Allegis Advisor Group and any affiliated companies (hereinafter collectively "Allegis") and any Authorized Recipient (as defined below) to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or (2) market Insurance Products and Services to me.

"Insurance Products and Services" means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also include long term care or other types of health insurance.

Classes of Persons Authorized to Disclose My PHI: I authorize any health care provider, including any doctor, hospital or medically-related facility, nurse, pharmacy, physician, practitioner, or practitioner practice group (each an "Authorized HCP"), and any insurance company, HMO/PPO or similar organization, employer or, except as may be limited by state law, any other organization, institution or person that has my PHI to disclose to Allegis or any Authorized Recipient, any such records or information as provided under this authorization.

Classes of Persons Authorized to Receive My PHI: PHI received by Allegis may be disclosed under this authorization to any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described (each an "Authorized Recipient").

Further Disclosure Authorization: I authorize each Authorized Recipient to further disclose my PHI as necessary to carry out the purposes under this authorization. I understand and acknowledge that PHI that is redisclosed by the Authorized Recipient may no longer be protected by law. I further acknowledge that some state and federal laws prohibit the further disclosure of information regarding the diagnosis, prognosis and treatment of drug or alcohol abuse, communicable diseases or infection including sexually-transmitted diseases or HIV without specific written consent. I hereby authorize Allegis and each Authorized Recipient to further disclose the foregoing information to the extent such disclosure is necessary in order to carry out the purposes under this authorization.

Expiration of Authorization: This authorization shall remain valid for two (2) years after the date signed below.

Right to Revoke: I understand that I may revoke this authorization at any time by sending a written request for revocation to Allegis or to any Authorized HCP at such address designated to me. Any revocation of this authorization shall not apply to the extent that any person has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

This authorization complies with the provisions of the HIPAA Privacy Rule governing authorizations (45 C.F.R. Sec. 164.508). I understand that this authorization is a requirement for the underwriting, sale or settling of Insurance Products and Services and Allegis may condition enrollment, eligibility, benefits, sale or settling of Insurance Products and Services on whether I sign this authorization.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. I certify that I am executing and delivering this authorization freely and voluntarily as of the date written below. I further certify that I have received and retained a copy of this signed authorization for future reference.

Insured/Proposed Insured Signature	Insured/Proposed Insured Name (print)	Date (mm/dd/yyyy)

Authorized Representative Signature	Authorized Representative Name (print)	Date (mm/dd/yyyy)	Relationship/Authority to Represent

AUTHORIZATION FOR USE AND DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION (NPI)

I, the Policy Owner/Proposed Policy Owner, authorize Allegis Advisor Group or any affiliated company (hereinafter collectively "Allegis") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient, as such terms are defined below. This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Allegis and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or; (2) market Insurance Products and Services to me.

I, the Insured/Proposed Insured (if different than the Policy Owner/Proposed Policy Owner), authorize Allegis Advisor Group or any affiliated company (hereinafter collectively "Allegis") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient (as such terms are defined below). This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Allegis and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

"Nonpublic Personal Information" means information, including, without limitation, nonpublic personal, financial, health and medical information about the Policy Owner and Insured (if different than the Policy Owner) and the Policy Owner/Insured's identity as an owner/insured under a Life Insurance Policy that is obtained, whether from the Policy Owner/Insured, any of the Policy Owner's/Insured's agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

"Authorized Recipient" includes any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described.

"Insurance Products and Services" means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also include long term care or other types of health insurance.

The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each agree and consent that this authorization shall be effective from the date hereof until the earlier of (a) the date that is two (2) years after the date hereof, or (b) an earlier date as may be required by applicable law or regulation. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) have the right to revoke this authorization, at any time, by providing written notification to Allegis.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each certify that he or she is executing and delivering this authorization freely and voluntarily as of the date written below. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) further certify that the authorization is written in plain language and acknowledge that each has received and retained a copy of this signed authorization for future reference.

_____	_____	_____
Insured/Proposed Insured Signature	Insured/Proposed Insured Name (print)	Date (mm/dd/yyyy)

HIPAA AUTHORIZATION FORM This Authorization is HIPAA compliant

Date	Advisor Name	Advisor Phone #

Name of Proposed Insured	Date Of Birth (MM/DD/YY)	Social Security Number
Drivers License Number	State	

The purpose of this Authorization is to permit Allegis Advisor Group to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, facts about my mental and physical health, drug/alcohol abuse treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits.

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information about me to release such information to Allegis Advisor Group, and its authorized representatives.

I specifically authorize the companies listed below to receive information from, and to release information to, Allegis Advisor Group. I also specifically authorize Allegis Advisor Group and the companies listed below to release information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB*) to release information directly to any company listed below, upon such insurer's request, provided the insurer is a member of MIB.

This Authorization shall be effective for two years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to Allegis Advisor Group, 10235 South Jordan Gateway, South Jordan UT 84095. Any action taken in reliance of this authorization prior to the notice of the revocation shall be valid. I understand that any information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy rules.

I acknowledge that I have read and understand the above and agree that this authorization was completed prior to my signature. I further agree that a copy of this authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Allegis Advisor Group and/or any third party designated herein.

Proposed Insured's/Guardian or Custodian/Authorized Representative Signature	Print Name	Date

Broker/Advisor/Agency/Firm Signature	Print Name	Date

Company List

AIG/American General
AIG Annuity Access
Allianz
Allianz Life of NY
American National Insurance Company
American Investors Life
Ameritas
Assurity
AXA Equitable
Banner Life/Legal & General America
Brighthouse
Cincinnati
Columbus Life
Equitable Life and Casualty
Equitrust
Fidelity Life
Fidelity Security
Fort Dearborn Life
Global Atlantic
Illinois Mutual
Integrity Life
John Hancock Life
John Hancock LTC
John Hancock of NY
John Hancock USA
Lafayette Life
Liberty Life Insurance/RBC
Life of the Southwest
Lincoln Life of NY
Lincoln National
Lloyd's of London
Mass Mutual
MedAmerica
MetLife DI
Midland National
Minnesota Life/Securian
Mutual of Omaha
Mutual Trust
National Life
Nationwide/Provident Mutual
New York Life
North American
North American of NY
OM Financial Life Insurance Co.
OM Financial Life Insurance Co of NY
Ohio National
Pacific Life
Penn Mutual
Phoenix Life Insurance Co.
Principal National Life Insurance
Principal Life Insurance
Protective Life Insurance
Prudential Insurance Company of America
Pruco Life Insurance Co
Reliance Standard
Savings Bank Life Insurance Co of MA
Security Mutual of NY
Standard Insurance Company
Symetra
TIAA-CREF
Transamerica Insurance Company
Transamerica of NY
Union Central Life
United of Omaha
Voya
Western Reserve Life
William Penn of NY
Zurich

Other Company	Insured Initials (must be initialed to be valid)

Allegis Advisor Group will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured.

* MIB is a not for profit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. MIB, Inc. PO Box 105 Essex Station, Boston, MA 02112 or call (617) 426-3660.