CLEAR FIELDS

GPEZ Insurance Request Form

Date: _____

App. Last Name: _____

APPLICANT INFORMATION

FULL NAME (include former names)	GENDER	DOB (mm/dd/yyyy)	BIRTH STATE	SSN/TIN
	☐ M ☐ F			

STREET ADDRESS	CITY	STATE	ZIP CODE	YEARS @ ADDRESS

PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS

DRIVER'S LICENSE #	STATE	EXPIRES	OCCUPATION / COMPANY	LOCATION (City)	YRS IN JOB

EARNED INCOME (annual)	UNEARNED INCOME (annual)	TOTAL HSHOLD INCOME (annual)	NET WORTH	BANKRUPTCY last 5 years or intention to file:
$	$	$	$	☐ No ☐ Yes Date Discharged:

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Civil Union
- ☐ Domestic Partner

US Citizen ☐ Yes ☐ No *If "No", complete one of the sections below.*

RESIDENT WITH LEGAL PERM. STATUS:	*TEMPORARY (NON-RESIDENT) WITH VALID VISA:*		
Green Card / Visa Type:	Visa Type:	Visa #:	
Number:	Cntry of Citizenship:	Passport #:	
Expiration Date:	Exp. Date:	Date of Entry (US):	I-94 Exp. Date:

PROPOSED INS. PLAN

CARRIER	TYPE	PRODUCT (term /guar to age)	FACE AMOUNT	PREMIUM	MODE
	☐ TERM ☐ UL ☐ WL ☐ IUL		$	$	☐ Mo ☐ Semi ☐ Qtr ☐ Ann

RIDERS	CLASS QUOTED	HOW SUBMITTED	DATE SUB'D	PERS or BUS	CVAT or GPT	DB: Inc/Lev	1035 EXCH AMT
		☐ eApp ☐ Paper ☐ Drop Tkt					$

POLICY OWNER *(if other than the applicant)*

FULL NAME	RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN	DRIVER'S LICENSE #	STATE ISSUED

STREET ADDRESS	CITY	STATE	ZIP CODE

PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS

BENEFICIARY INFORMATION

FULL NAME	RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN	PERCENTAGE	TYPE
				%	☐ Primary ☐ Contingent
				%	☐ Primary ☐ Contingent
				%	☐ Primary ☐ Contingent

CUR. & APPLIED FOR POLICIES *(past 6 mos)*

COMPANY	POLICY NUMBER	YEAR ISSUED	FACE AMOUNT	REPLACING?	TYPE*	1035 EXCHANGE?
			$	☐ Yes ☐ No		☐ Yes ☐ No
			$	☐ Yes ☐ No		☐ Yes ☐ No
			$	☐ Yes ☐ No		☐ Yes ☐ No

* Type: **i** = individual **b** = business **g** = group **p** = pending

PAYOR / EFT INFORMATION

PAYOR FULL NAME (if other than insured)	RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN

BANK	ROUTING NUMBER	ACCOUNT NUMBER	DRAFT DAY

NAME ON ACCOUNT	DRAFT	DRAFT DATE	COLLECTED w/ APP	BIND COVERAGE?
	☐ @ Issue ☐ On Receipt ☐ Future ☐ For TLA		$	☐ Yes ☐ No

This document is for data collection only and does NOT constitute a formal, binding contract for insurance.

v07/19/21

Underwriting Questions

Applicant's Name: _____ Date: _____

Date of Birth: _____

HEIGHT ' "	WEIGHT	NICOTINE USE: ☐ NEVER ☐ CURRENT* ☐ QUIT*(Date:) *TYPE/AMT/FREQ:
		ALCOHOL USE: ☐ NEVER ☐ CURRENT** ☐ QUIT(Date:) ** TYPE/# PER WK:

BLOOD PRESSURE Systolic: Diastolic:
Taking BP Medication: ☐ Yes ☐ No

CHOLESTEROL Level: _____ HDL Ratio:_____
Taking Cholesterol Medication: ☐ Yes ☐ No

Check any that apply and provide details: condition, onset dates, duration, symptoms, complications, severity, treatment, medication, treating provider, etc.

☐ **CARDIOVASCULAR** Including but not limited to aneurysm, angina, blood clot, chest pain, coronary artery disease, congestive heart failure, heart attack, heart murmur, irregular heart beat, mini-stroke (TIA), peripheral vascular disease, shortness of breath, stroke, or other disease, disorder or blockage of the arteries or veins, etc.

☐ **DIABETES** A1c LEVEL: _____ Age Diagnosed:_____ Maintenance: ☐ Oral ☐ Insulin ☐ Diet & Exercise

☐ **CANCER** Including but not limited to cancer, cysts or other similar abnormalities, leukemia, lymphoma, masses, tumors or growths, etc.

☐ **RESPIRATORY** Including but not limited to asthma, chronic bronchitis, emphysema, COPD, cystic fibrosis, sleep apnea or other breathing or lung disorder, etc.

☐ **OTHER CONDITIONS** Including but not limited to AIDS virus, arthritis, connective tissue disorder, Crohn's disease, digestive issues, epilepsy/convulsions, gastric/peptic ulcers, kidney/ liver/pancreas disease, multiple sclerosis, muscle disorders, prostrate disease, psychiatric care or counseling, rheumatoid arthritis, ulcerative colitis, etc.

FAMILY HISTORY	Mother	Father	Sibling (gender)	Sibling (gender)	Sibling (gender)
Age if Living					
Age @ Death					
Cause of Death					

PRESCRIPTION INFORMATION List all prescriptions taken in the **last 5 years** (use notes section if needed)

PRESCRIPTION	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN	TIME PERIOD USED	REASON

PHYSICIAN VISIT/ HOSPITALIZATION / MEDICAL PROCEDURE / SURGERY / DIAGNOSTIC TEST List all **last 5 years** (use notes section if needed)

PHYSICIAN / FACILITY	CITY / STATE	DATE(S)	REASON / OUTCOME

HIGHER RISK ACTIVITIES

Check any activity that applicant engages in / plans to engage in:

- ☐ Ballooning
- ☐ Bungee jumping
- ☐ Hang Gliding / Parachuting / Sky Diving
- ☐ Motor Sports of any type
- ☐ Pilot / Student Pilot / Flight Crew
- ☐ Rock / Mountain Climbing
- ☐ Scuba / Skin Diving
- ☐ Spelunking

MISCELLANEOUS INFORMATION

Check any that apply to applicant & provide details in notes section:

- ☐ Had a life insurance application modified, rated, declined, postponed
- ☐ Convicted or awaiting trial for a felony
- ☐ Planning to travel outside the U.S. for business or pleasure in the next 12 months. ***If so, provide travel dates and indicate which countries.***
- ☐ Member of the Armed Forces or planning to apply
- ☐ Pled guilty or no contest to any driving violations in last 5 years, including DUI
- ☐ Undergoing treatment for alcohol or drug dependency or have in past 5 years

HOW LONG HAS BROKER BEEN ACQUAINTED WITH APPLICANT: _____

Applicant's Last Name: _____ Date: _____

ADDITIONAL NOTES

(if needed)

ADDITIONAL SPACE

(if needed)

PRESCRIPTION INFORMATION List all prescriptions taken in the **last 5 years** (use notes section if needed)					
PRESCRIPTION	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN	DURATION	REASON

PHYSICIAN VISIT/ HOSPITALIZATION / MEDICAL PROCEDURE / SURGERY / DIAGNOSTIC TEST List all **last 5 years** (use notes section if needed)			
PHYSICIAN / FACILITY	CITY / STATE	DATE(S)	REASON / OUTCOME

Proposed Insured _____ Social Security Number _____

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 Gene Pleasants Agency 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 Gene Pleasants Agency 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 Gene Pleasants Agency 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 Gene Pleasants Agency 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 Gene Pleasants Agency 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 Gene Pleasants Agency 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.

_____ _____

Signature of Insured/Proposed Insured Date

_____ _____ _____

Signature of Authorized Representative Date Relationship/Authority to Represent

Proposed Insured _____ Social Security Number _____

AUTHORIZED RECIPIENTS

INSURANCE CARRIERS

Allianz Life Insurance Company of North America
American Equity Investment Life Insurance Company
American General Life Insurance Company
American National Insurance Company
American National Life Insurance Company of NY Americo
Ameritas Life Insurance Corp of New York
Assurity Life Insurance Company
Athene Annuity
Equitable Life Insurance Company
Banner Life Insurance Company/Legal & General Boston
Mutual Life Insurance Company
Brighthouse Life Insurance Company
Brighthouse Life Insurance Company of New York
(The) Cincinnati Insurance Companies
Columbian Life Insurance Company
Columbian Mutual Life Insurance Company
Equitable Life Insurance Company
Fidelity Security Life Insurance Company
Fidelity Security Life Insurance Company of New York
First Forethought Life Insurance Company
Gerber Life Insurance Company
Great American Life Insurance Company
Guardian Life Insurance Company
Illinois Mutual Life Insurance Company
Integrity Life Insurance Company
John Hancock Life Insurance Company (USA)
John Hancock Life Insurance Company of NY
Lincoln Life Insurance & Annuity Co. of NY
Lincoln National Life Insurance Company
Mass Mutual Life Insurance Company
Metropolitan Life Insurance Company
Mutual of Omaha
National Guardian Life Insurance Company
National Life Insurance Company/Life Insurance Company of the
Southwest Nationwide Life Insurance Company
Nationwide Life Insurance Company
New York Life
North American Co. for Life & Health
Ohio National Life
OneAmerica
Pacific Life & Annuity Company
Pacific Life
Penn Insurance & Annuity Company
Penn Mutual Life Insurance Company
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life & Annuity Insurance Company
Protective Life Insurance Company
Prudential Life Insurance Company
Reliance Standard
Sagicor Life Insurance Company
Securian Life Insurance Company/Minnesota Life Insurance
Company Symetra Life Insurance Company
Sons of Norway
Symetra National Life Insurance Company of New York
The Standard
The Standard Life Insurance Company of New York
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
United of Omaha Life Insurance Company

_____ _____
Signature of Insured/Proposed Insured Date

_____ _____ _____
Signature of Authorized Representative Date Relationship/Authority to Represent