



Pre-App Collection Form

Date: _____

Excellent data collection tool for iGo/eApps

App. Last Name: _____

Not an Application for Insurance

APPLICANT INFORMATION

FULL NAME (include former names)				GENDER M F	DOB (mm/dd/yyyy)	BIRTH STATE	SSN/TIN	
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 <i>If "No", complete one of the sections below.</i>							
	RESIDENT WITH LEGAL PERM. STATUS: Green Card / Visa Type: Number: Expiration Date:			TEMPORARY (NON-RESIDENT) WITH VALID VISA: Visa Type: Cntry of Citizenship: Exp. Date:				Visa #: Passport #: Date of Entry (US): I-94 Exp. Date:

PROPOSED INS. PLAN

CARRIER	TYPE TERM UL WL IUL	PRODUCT (term / guar to age)	FACE AMOUNT \$	PREMIUM \$	MODE Mo Semi Qtr Ann	
RIDERS	CLASS QUOTED	HOW SUBMITTED eApp Paper Drop Tkt	DATE SUB'D	PERS or BUS	CVAT or GPT	DB: Inc/Lev 1035 EXCH AMT \$

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 @ Issue Future	On Receipt For TLA	DRAFT DATE	COLLECTED w/ APP \$	BIND COVERAGE? Yes No	

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



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: _____	CHOLESTEROL Level: _____ HDL Ratio: _____
Taking BP Medication: Yes No	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, prostate 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)

Large empty rectangular box for additional notes.

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

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

Signature of Insured/Proposed Insured

Date

Signature of Authorized Representative

Date

Relationship/Authority to Represent