2900 Bristol St. Suite B300
Costa Mesa, CA 92626
949.955.0255 phone
949.955.9215 fax

Informal Inquiry

NOT AN APPLICATION FOR LIFE INSURANCE

Agent Name: _____ Date: _____
Agent Phone(s): _____ Agent SS#: _____
Agent Address: _____
Agent Email: _____
Contact Person (if different): _____

Face Amount: $_____ Product Type: _____
Applicant: _____ Male Female Height _____ Weight: _____
DOB: _____ SS#: _____ Driver's License #: _____ State of issue: _____
Place of Birth: _____ Phone: _____ Cell: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____ What Company: _____ How Long: _____
Income: _____ Assets: _____ Liabilities: _____ Net Worth: _____

Insurance Currently In Force:

Company	Year Issued	Face Amount	Offer	To Be Replaced?

Do you have any plans for foreign travel? (If yes, please advise, when, where, purpose and how long)
Have you ever used any kind of tobacco or any other products containing nicotine? Yes No
If yes, please indicate which form: cigarette pipe nicotine gum/patch chewing tobacco
cigar (how many per year) _____

Has nicotine use been discontinued? Yes No Date discontinued: _____
Do you use alcoholic beverages? Yes No

Type_____ Frequency_____ Amount_____

Do you have any knowledge that an application or informal inquiry has been seen by any carriers with the last year? Yes No

Carrier	Offer	Decline

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Do you have a history of?

High Blood pressure? What medications are you taking? _____

Heart conditions/Coronary Artery Disease? _____ Heart Attack? _____

Diabetes? At what age were you first diagnosed? _____

What is the therapy and doses at present time?

Diet Only Insulin Oral Medication: _____

Arthritis? Location/medication: _____

Asthma? **COPD?** (Chronic Obstructive Pulmonary Disease): _____

Cancer? Location/medication: _____

When was the diagnosis? _____ What is the stage of the Cancer? _____

Was there a biopsy? _____ Last date of radiation or chemotherapy? _____

In the past 5 years, have you been convicted of any driving under the influence of alcohol or other drugs violations, or had your driver's license suspended, restricted or revoked? Yes No

If "Yes," please provide details including dates_____

Family Health History:	**Age** (or age at death)	**History of Heart Disease**	**History of Cancer All Types**
Mother	_____	yes ___ no ___	yes ___ no ___
Father	_____	yes ___ no ___	yes ___ no ___
Sister(s)	_____	yes ___ no ___	yes ___ no ___
Brother(s)	_____	yes ___ no ___	yes ___ no ___

Additional Medical Information:

_____

_____

Please list all physicians seen within the past ten (10) years:

Physician Name: _____ Phone: (_____) _____
Address: _____
Date Last Seen: ____/____/____ Reason: _____

Physician Name: _____ Phone: (_____) _____
Address: _____
Date Last Seen: ____/____/____ Reason: _____

Physician Name: _____ Phone: (_____) _____
Address: _____
Date Last Seen: ____/____/____ Reason: _____

Physician Name: _____ Phone: (_____) _____
Address: _____
Date Last Seen: ____/____/____ Reason: _____

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HIPAA COMPLIANT AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured(s)/Patient(s) (Please print)

First MI Last DOB Month/Day/Year

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insure, reinsurer, insurance support organization, the Medical Information Bureau, Inc. consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, and those person authorized to represent them; and BGA Insurance; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

Accordia Life
Allianz
American General Life Ins.
American National
AXA
Banner Life
Columbus Life
Conseco
F & G
Genworth Financial Co.
Guardian Life Insurance Co.
Indianapolis Life
ING
Jackson National
John Hancock Life Ins. Co.
John Hancock USA
Kansas City Life
Life of Southwest
Lincoln Financial Group
Mass Mutual
MetLife
Metropolitan Life Insur. Co.
Minnesota Life
Mutual of Omaha
Mutual Trust Life
National Western
Nationwide
New York Life
North American
Ohio National Life
Old Mutual
One America
Pacific Life Insur. Co.
Penn Mutual
Petersen International
Principal Life Insurance Co.
Principal National Life
Protective Life
Prudential Life Ins. Co.
ReliaStar
Security Life of Denver
Security Mutual
Standard Life
LMSuperior Medical Group
Symetra
Tellus
Transamerica Life Insurance
Company Union Central
United of Omaha
US Life
VOYA
William Penn
Zurich

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Company

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

I understand the insurers named above and their reinsurers will use this information to help determine my eligibility for insurance. The insurance agent may also use this information to help update and improve my insurance program.

I agree that the above named parties may also disclose my information to other insurers, reinsurers, the Medical Information Bureau, Inc. and other persons or organizations performing business or legal services in connection with the underwriting process, or as may be otherwise lawfully required.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to BGA Insurance at the above service office address. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information but will not be re-disclosed by BGA Insurance except as authorized by me or as required by law.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that my medical providers may not refuse treatment or payment of health care services regardless if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization for release of my complete medical records, the carriers listed above may not be able review my medical file. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of proposed insured	Name of Proposed Insured
Signature of additional proposed insured (if applicable)	Name of Additional Proposed Insured
City / State	Month / Day / Year