

INFORMAL INQUIRY

NAME _____ DOB _____ GENDER _____

RESIDENTIAL ADDRESS _____

SS# _____ PLACE OF BIRTH _____ DL# _____

TOBACCO USE _____ HEIGHT _____ WEIGHT _____

INSURANCE AMT \$ _____

PLAN OF INSURANCE(UL/SUL/TERM) _____

INSURANCE INFORCE \$/ INSURANCE CARRIERS:

REPLACEMENT/1035? _____

MEDICAL HISTORY

(include specialists, treatments and hospitalizations)

PRIMARY PERSONAL PHYSICIAN

ADDRESS / PHONE

DATE LAST SEEN / REASON

CONSULTING PHYSICIAN

ADDRESS / PHONE

DATE LAST SEEN / REASON

SURGEONS, INSTITUTIONS, HOSPITALS

ADDRESS / PHONE

APPROXIMATE DATE / REASON

CURRENT MEDICATIONS

MISCELLANEOUS

AVIATION DETAILS(pilot/student pilot)

Date of last flight/aircraft Type: _____

Total Hours Flown: _____

Number of flights in last and next 12 months: _____

FOREIGN TRAVEL(what foreign countries and cities/frequency/length/purpose)

AVOCATION DETAILS – Please provide complete details

1. Scuba Diving _____

2. Sky Diving _____

3. Parachuting _____

4. Hang Gliding _____

5. Ballooning _____

6. Racing/Motor-Vehicle Type _____

7. Rock/Mountain Climbing _____

8. Other(Specify) _____

ADDITIONS COMMENTS/ REMARKS

AGENTS REPORT

SUBMITTED BY: _____

ADDRESS/ PHONE/ EMAIL _____

WHAT ARE THE PRODUCT AND PREMIUM GOALS OF THIS CASE?

CARRIERS SUBMITTED TO _____

HOW DO YOU WANT ILLUSTRATIONS RUN? _____

Authorization To Obtain And Release Information

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations and the authorized representatives of these companies may need to collect information on me in regard to proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of the proposed insured to furnish to the insurance companies named below the types of information specified in this Authorization.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit, or other personal traits.

The information will be used by the insurance companies named below and/or their reinsurers to determine eligibility for insurance and claims. The information may also be used by the insurance agent to aid in updating and improving my insurance program.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Bureau, Inc., or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I acknowledge receipt of the Notice to Proposed insured and Notice of Information Practices.

INSTRUCTION TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

AIG	Hartford	MetLife/ Travelers	Principal Financial	Sun Life Of Canada
American General	Indianapolis Life	Met Life Investors	Protective Life	Transamerica
AXA/ MONY	ING USA	Midland National	Prudential	Trinity Financial Services
Cambridge	Jefferson Pilot Financial	New England	Reliastar	US Financial Life
Canada Life	John Hancock/ Manulife	New York Life	Security Connecticut	West Coast Life
First Coventry	Life Settlement Insights	Ohio National Life	Sec. Life of Denver	David Belcher and Associates
	Lincoln Benefit Life	Pacific Life	Southland Life	Berger Insurance Services
First Penn Pacific	Lincoln Financial Group	Potomac Group West		Underwriting Solutions

Signed at _____ this _____ day of _____ 20 _____

_____ X _____
Name of Proposed Insured **Signature of Proposed Insured**

NOTICE TO PROPOSED INSURED

In compliance with Public Law 90-508 (Fair Credit Reporting Act), I understand that as part of the underwriting procedure, any of the insurance companies listed may secure on me a routine inquiry involving interviews with third parties such as family members, business associates, financial sources, friends, or others who may have information concerning my character, general reputation, personal characteristics and mode of living. I further understand that upon written request from me, additional information will be provided me concerning the nature and scope of the inquiry if one is actually made.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies, which operates an informational exchange bureau on behalf of its members.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone (617) 426-3660.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administrating your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The Companies may also seek information, from others, such as medical professionals who have treated you, hospitals, other insurance companies, consumer reporting agencies, or the Medical Information Bureau, Inc. (MIB).

In certain circumstances, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about and to see a copy, if you wish, of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES, AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO Berger Insurance Services.

Berger Insurance Services

Health Insurance Portability and Accountability ACT (“HIPAA”)

HIPAA Authorization

/ /

Name of Proposed Insured/Patient Date of Birth Social Security Number

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an “Authorized Discloser”) to provide Berger Insurance Services and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Berger Insurance Services the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Berger Insurance Services in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Berger Insurance Services with any information or forms in connection with any life insurance policy and under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Disclosure by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, and of my medical information disclosed by any Authorized Discloser to Berger Insurance Services may be redisclosed by Berger Insurance Services and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained in this Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photostatic or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

*NAME OF INSURED _____

*SIGNATURE OF INSURED _____

*DATE _____

*NAME OF OWNER (If other than Insured) _____

*SIGNATURE OF OWNER (If other than Insured) _____

*DATE _____

*NAME OF WITNESS _____

*SIGNATURE OF WITNESS _____

*DATE _____