INFORMAL INQUIRY

This form is used to review insurance opportunities and is *not* an application for life insurance. Incomplete information can lead to an inaccurate assessment from insurance carriers. Please email the completed form to newbusiness@idesign-network.com.

IDN INSURANCE DESIGN NETWORK LLC

Producer & Product Information

Producer Name: _____ Date: _____

Product Description: _____ Face Amount: _____

Proposed Insured Information

Applicant Name: _____ ☐ Male ☐ Female DOB: _____

SS#: _____ Height: _____ Weight: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ US Citizen: ☐ Yes ☐ No

Annual Income: _____ Assets: _____ Liabilities: _____ Net Worth: _____

Premium Tolerance/Offer needed to place: _____

Can you provide Third Party Financials signed by a currently licensed CPA? ☐ Yes ☐ No

In Force Policy Information

Please List all current insurance policies that are in force:

Company	Year	Face Amount	Being Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Do you have knowledge of an application or inquiry being sent to any carrier in the last year? ☐ Yes ☐ No

Company	Offer Amount	Placed?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Activity and Medical Information

Do you participate in any hazardous activities? ☐ Yes ☐ No (*if yes, please complete below section*)

☐ Flying ☐ Scuba ☐ Climbing ☐ Other _____

Details: _____

Do you have any plans for foreign travel? ☐ Yes ☐ No (*if yes, please complete below section*)

Details: _____

Have you ever used any kind of tobacco product? ☐ Yes ☐ No (*if yes, please complete below section*)

Forms used: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Other _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _____

Date last used: _____

Activity and Medical Information *(continued)*

Do you have a history of the following:

High Blood Pressure: ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease: ☐ Yes ☐ No

(*if yes, please complete below section)*

☐ Heart Attack ☐ Bypass Surgery ☐ Stent(s)

Date of event:_____ Date of Last EKG/Stress Test:_____

Diabetes: ☐ Yes ☐ No (*if yes, please complete below section)*

At what age were you diagnosed?_____

Most recent A1c level:_____ Current glucose reading: _____

List all diabetes medications currently prescribed:

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Medication:_____ Dosage: _____

Respiratory Disease: ☐ Yes ☐ No (*if yes, please complete below section)*

Have you been hospitalized for this condition: ☐ Yes ☐ No

Have you been diagnosed with sleep apnea: ☐ Yes ☐ No

Are you currently using a CPAP: ☐ Yes ☐ No

Date of last pulmonary function test:_____

Cancer: ☐ Yes ☐ No (*if yes, please complete below section)*

Type of cancer:_____

Was there a biopsy: ☐ Yes ☐ No Cancer stage if known: _____

Date of surgery, if any: _____

Date of completion of radiation treatment: _____

Date of completion of chemotherapy:_____

Please list any medical conditions not indicated above:_____

_____

_____

Family Medical History

Family Member	History of Heart Disease	History of Cancer	Type of Cancer
Mother	☐ Yes ☐ No	☐ Yes ☐ No	
Father	☐ Yes ☐ No	☐ Yes ☐ No	
Sibling 1	☐ Yes ☐ No	☐ Yes ☐ No	
Sibling 2	☐ Yes ☐ No	☐ Yes ☐ No	

Senior Supplement

Have you been diagnosed with Alzheimer's or dementia? ☐ Yes ☐ No

Have you ever been treated for memory problems? ☐ Yes ☐ No

Do you require assistance for walking? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Do you exercise daily? ☐ Yes ☐ No

Do you require assistance with daily chores? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been diagnosed with depression? ☐ Yes ☐ No

Have you ever been diagnosed with anemia? ☐ Yes ☐ No

Please provide details of any "Yes" answers:

_____

_____

_____

_____

_____

_____

Please list all current medications:

_____

_____

_____

_____

Physician Information

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:_____

Additional Information

Please list any additional information that would pertain to applying for an insurance policy:

_____

_____

_____

_____

_____

_____

_____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number

This form is HIPAA compliant

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below. Insurance Design Network, brokers, contractors, employees, representatives, and agents working through AIN Member Firm and Insurance Design Network for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Abacus Life	Equity Release	Life Insurance of the Southwest	Principal Life Insurance Company
Advantage Insurance Network, Inc. (AIN)	Divergent Financial Marketing	LifeShare	Principal National Life Insurance Company
Allianz	Examination Management Services, Inc.	Lincoln Financial/ Lincoln Life	Professional Underwriting Services
American General Life (AIG)/ Corebridge	Fasano Associates, Inc.	Lincoln National Life Insurance Co.	Protective Life Ins Co.
American National	Fidelity & Guaranty Life Ins. Co.	Massachusetts Mutual	Prudential Life Ins. Co. / Pruco Life RSA Medical
Americo	First Global Financial & Insurance	Metropolitan Life	SBLI
Assurity Life	First Insurance Funding	MetLife Investors USA Insurance Co.	Security Mutual
Accordia Life	Foresters	Minnesota Life / Securian Financial	Standard Life
Ameritas	General American Life Ins. Co.	Mutual of Omaha	Superior Medical Group
AVS, LLC	Global Insurance Underwriters	National Life of Vermont	Symetra
AUS Underwriting	Guardian Life Ins. Co.	National Western	Transamerica Life Insurance Co.
AXA / MONY / AXA Equitable	Human API	Nationwide Life & Annuity Co.	21st Services
Banner Life/Legal & General	Industrial Alliance Pacific	New Investor World, Inc.	United of Omaha
Beneficial Financial Group	Insurance Design Network	New York Life Insurance Co.	USG Annuity & Life
Bragg Associates	ISC Services	North American Co.	Voya - ReliaStar Life of New York
Brighthouse Financial	Jetstream	OneAmerica/State Life	Voya – ReliaStar
AIN Member Firm	John Hancock Life Ins. Co.	Optima Financial	Voya – Security Connecticut Life
Columbus Life	John Hancock USA	Pacific Life	Voya - Security Life of Denver
Concord Capital/INSCAP	Lafayette Life	Penn Mutual	William Penn Life Ins. Co.
Coventry First, LLC	Lewis and Ellis, Inc.	Premium Funding Group (PFG)	Zurich American Life Insurance Company

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name:_____

Physician Address:_____,

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to Insurance Design Network, the Insurers and Agencies listed afore and to:

Agent/Producer Name:_____.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
continued

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or 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, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

Signed at_____ this_____day of_____20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X_____ Printed Name:_____

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews wit h your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation; personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112 , telephone number: 866-692-6901.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insure rs named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

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

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.