Applicant Pre-Screening

☐Male ☐Female Client's Name: _____

DOB: _____ Agent's Name: _____

Height: ____ft. ____in. Desired Face Amount: $_____

Weight: _____lbs. Type of Insurance: ☐Term, ☐UL, ☐Other: _____

1. Have you ever used nicotine products or substitutes in any form?
   ☐Never Used
   ☐Currently Use: ☐cigarettes, ☐cigars, ☐pipe, ☐chewing tobacco, ☐nicotine patch/gum
   Amount and Frequency: _____
   ☐Totally Stopped, Date of Last Use: _____

2. How often do you drink alcoholic beverages? ☐Never, ☐Totally Stopped, ☐Use Now. (If you have totally stopped consuming alcohol, please describe the reason why in the comments section below.)

3. How many alcoholic beverages do you consume per day? ☐3 or less, ☐4-6 drinks, ☐7 or more, ☐N/A

4. Non-Medical History: **(Please list the details of any yes answers in the comments section.)**

a. Have you ever flown, or do you intend to fly, as a pilot, student pilot, or crew member other than for a scheduled commercial airline?	☐Yes ☐No
b. Do you intend to travel outside the US in the next 2 years?	☐Yes ☐No
c. Do you participate in hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving?	☐Yes ☐No
d. Has your driver's license ever been suspended or revoked?	☐Yes ☐No
e. Have you ever been convicted of, or pled guilty or no contest to reckless driving or driving under the influence of alcohol or drugs?	☐Yes ☐No
f. In the past 5 years have you had more than 2 moving violations?	☐Yes ☐No
g. Have you ever been convicted of a misdemeanor or felony?	☐Yes ☐No
h. Have you ever filed for bankruptcy or had any judgments or liens filed against you?	☐Yes ☐No

Comments: _____

_____

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_____

Medical History: **(Please list the details of any yes answers in the comments section.)**

5. Have you ever had, been treated for, or been medically advised to be treated for, any of the following?

Alcoholism or Drug Use	☐Yes ☐No	Kidney Disorder	☐Yes ☐No
Angina	☐Yes ☐No	Lupus/Scleroderma	☐Yes ☐No
Asthma	☐Yes ☐No	Mental Illness	☐Yes ☐No
Blood Disorder	☐Yes ☐No	Muscular Dystrophy	☐Yes ☐No
Bronchitis	☐Yes ☐No	Neurologic Disorder	☐Yes ☐No
Cancer	☐Yes ☐No	Palpitations/Arrhythmia	☐Yes ☐No
Chest Pain	☐Yes ☐No	Pancreatitis	☐Yes ☐No
Cirrhosis	☐Yes ☐No	Paralysis	☐Yes ☐No
Clotting Disorder	☐Yes ☐No	Peripheral Vascular Disease	☐Yes ☐No
Colitis/Ileitis	☐Yes ☐No	Pituitary Disorder	☐Yes ☐No
Coughing Up of Blood	☐Yes ☐No	Prostate Disorder	☐Yes ☐No
Chronic Lung Disorder	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Depression	☐Yes ☐No	Seizures/Convulsions	☐Yes ☐No
Diabetes	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Dizziness/Fainting	☐Yes ☐No	Skin Disorder	☐Yes ☐No
Gastrointestinal Bleeding	☐Yes ☐No	Sleep Apnea	☐Yes ☐No
Headaches	☐Yes ☐No	Stroke	☐Yes ☐No
Heart Attack/Heart Disease	☐Yes ☐No	Sugar, Protein or Blood in Urine	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Suicide Attempt	☐Yes ☐No
Hepatitis	☐Yes ☐No	Thyroid Disorder	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Tuberculosis	☐Yes ☐No
High Cholesterol	☐Yes ☐No	Tumor, Mass or Lump	☐Yes ☐No
HIV	☐Yes ☐No	Ulcer/Gastritis	☐Yes ☐No

6. In the past year, has your weight changed more than 10 pounds? ☐Yes ☐No

7. Other than as prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens, or any prescription drugs? ☐Yes ☐No

8. Are you currently taking any prescription medications? ☐Yes ☐No (If yes, please list below.)

Medication & Dosage	Prescribed for:

9. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family? ☐Yes ☐No (If yes, please list family member, age of onset, diagnosis, age if living, or if deceased cause of death & age at death.)

Comments: _____

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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, Assent Marketing Group dba Lifemarketers, brokers, contractors, employees, representatives and agents working through Assent Marketing Group dba Lifemarketers for purpose of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Advantage Insurance Network, Inc.	**First Global Financial & Insurance**	**Lincoln National Life Insurance Co.**	**Prudential Life Ins. Co. / Pruco Life**
Allianz	**First Insurance Funding**	**Massachusetts Mutual**	**RSA Medical**
American General Life (AIG)	**First Penn**	**Metropolitan Life**	**SBLI**
American National	**Foresters**	**MetLife Investors USA Insurance Co.**	**Security Mutual**
Americo	**General American Life Ins. Co.**	**Minnesota Life / Securian**	**Standard Life**
Assurity Life	**Global Insurance Underwriters**	**Mutual of Omaha**	**Sun Life Ins. Co. of America**
Accordia Life	**GE Financial Assurance Co.**	**National Life of Vermont**	**Sun Life Ins. Co. of Canada**
Ameritas	**Genworth Life Insurance Co.**	**National Western**	**Superior Medical Group**
Assent Marketing Group	**Genworth Life and Annuity**	**Nationwide Life & Annuity Co.**	**Symetra**
AVS, LLC	**Guardian Life Ins. Co.**	**New Investor World, Inc.**	**Transamerica Life Insurance Co.**
AUS Underwriting	**Hartford Life Insurance Co.**	**New York Life Insurance Co.**	**Travelers Life & Annuity**
AXA / MONY / AXA Equitable	**Industrial Alliance Pacific**	**North American Co.**	**21st Services**
Banner Life	**ISC Services**	**Old Mutual Financial Network**	**Union Central Life**
Beneficial Financial Group	**John Hancock Life Ins. Co.**	**Pacific Life**	**United of Omaha**
Bragg Associates	**John Hancock USA**	**Penn Mutual**	**USG Annuity & Life**
Columbus Life	**Kestler Financial**	**Premium Funding Group (PFG)**	**Voya - ReliaStar Life of New York**
Concord Capital/INSCAP	**Lafayette Life**	**Pioneer Mutual**	**Voya – ReliaStar**
Coventry First, LLC	**Lewis and Ellis, Inc.**	**Phoenix Life**	**Voya – Security Connecticut Life**
Equity Key, LLC	**Life Insurance of the Southwest**	**Presidential Life**	**Voya - Security Life of Denver**
Equity Release	**Lifemarketers**	**Principal Life Insurance Company**	**West Coast Life Insurance Co.**
Examination Management Services, Inc.	**LifeShare**	**Principal National Life Insurance Company**	**Western Reserve Life**
Fasano Associates, Inc.	**Lincoln Benefit Life**	**Professional Underwriting Services**	**William Penn Life Ins. Co.**
Fidelity & Guaranty Life Ins. Co.	**Lincoln Financial/ Lincoln Life**	**Protective Life Ins Co.**	**Zurich American Life Insurance Company**
Additional Insurers and Agencies:			

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 Assent Marketing Group dba Lifemarketers, the Insurers and Agencies listed afore and to:
Agent/Producer Name:_____.
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.

Signed at _____ this _____ day of _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X_____Printed Name: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 with 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: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers 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.