

PLEASE FAX TO PRIVATE NUMBER: (305) 675-7787



1800 Sunset Harbour Drive, Marina Suite 3
Miami Beach, FL 33139
Office: 305.695.8052
Fax: 305.675.7787

Informal Inquiry

Full Name:	Sex:	DOB:	Date of last nicotine use: Specify tobacco: Using nicotine gum or patch?
Place of Birth:	Height:	Weight:	SS #: Dr. Lic #:
Address:			
Telephone:	Cell:	Fax:	Email:
Insurance Amount \$	Plan of Insurance:		

Medical History

Primary Care Physician (PCP)	Address & Phone Number	Date last seen	Reason
Consulting physician	Address & Phone Number	Date last seen	Reason

Institutions and/or hospitals	Address & Phone Number	Date	Reason

List all medications, including over-the-counter drugs and vitamins:

Family History: Have any immediate family members (parents, brothers, sisters) died prior to age 60? _____ Yes* _____ No

*If "yes," identify family member, cause of and age at death.

Avocation or special risk concerns: (flying, diving, climbing, driving, etc)? _____ Yes _____ No

Agent's Report

Submitted by: _____ Agency: _____

Phone #: _____ Fax #: _____ E-mail address: _____

What are the product and premium goals of this case? _____

What other carriers have reviewed this risk? Results? _____

What problems have you encountered so far? _____

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

American General/U.S. Life

I hereby authorize and request any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, or that of any member of my immediate family proposed for insurance to give to American General Life Insurance Company and its reinsurers any such information. A photographic copy of this authorization shall be valid as the original. Receipt is hereby acknowledged of the notices made a detachable part of this application pertaining to the Fair Credit Reporting Act and the Medical Information Bureau. I represent that the statements and answers recorded above are true and complete to the very best of my knowledge and belief.

Hartford

I authorize Hartford Life or Hartford Life and Accident Insurance Company (Hartford) to complete a Personal History Interview and to obtain an Investigative Consumer Report on me or on my children. I authorize the release of any medical or non-medical information that relates to: (1) past or current health conditions including illnesses; sicknesses; diseases; disabilities; disorders; accidents; or injuries; (2) confinements in any hospital; medical facility; or medical clinic; (3) outpatient treatment in any hospital; hospital emergency room; medical facility; or clinic; (4) treatment for alcohol abuse; drug abuse; or mental health protected by Federal Law. This information may be released by any person or organization that has records or knowledge of my health or of the health of my children, if they are applying for insurance. This includes any doctor; medical professional; health practitioner; therapist; counselor; hospital; clinic; insurer; reinsurer; consumer reporting firm; employer or the Medical Information Bureau (MIB). This information may be released for the purpose of determining eligibility for insurance under a new or existing policy. This information may be released to Hartford or to their legal representative. I understand that the MIB will release records of information only to Hartford. Hartford may release the information in their file(s) to: their reinsurers; the MIB; any other insurance company to whom I or my children apply for life or health insurance; or other persons and/or organizations performing business or legal services in connection with this application or a claim.

Mass Mutual Life Insurance Company

I have received the Notice about the Medical Information Bureau, Inc. (MIB). I have also received the Notice about the Fair Credit Reporting Act. I understand and authorize an investigative report to be made. This report may include information about my character, general reputation, personal characteristics, and mode of living. I hereby authorize certain parties that have any records or knowledge of me and my health (or my children and their health if juvenile insurance), to make such information available to the Company and its reinsurers. These parties include: any licensed physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, MIB, or other organization. I agree that a photo copy or facsimile of this authorization may be used to obtain information.

John Hancock USA

I hereby give permission to any physician, medical care provider, hospital, clinic, laboratory, insurance company or MIB, Inc. (The Medical Information Bureau) or any other similar person or organization to give The Company and to its reinsurers, information about me or any of my minor children who are to be insured. The information collected by The Company may relate to the symptoms, examination, diagnosis, treatment or prognosis of any physical or mental condition. Although information related to drug or alcohol abuse at any time, but any revocation will not affect such information that has already been collected and relied on by The Company. Information collected under this Authorization will be used by The Company to evaluate my application for insurance, to evaluate a claim for benefits, or for reinsurance or other insurance purposes. I understand that I have a right to receive a copy of this form. I agree that a photocopy of this form will be as valid as the original. This authorization will be valid for two years from the date shown below. I acknowledge receipt of the Notice of Disclosure of Information

Lincoln Financial Group, Inc.

I AUTHORIZE any medical professional, hospital, clinic, medical care institution, insurer, the Medical Information Bureau, Inc. consumer reporting agency, Social Security Administration, employer, or other person having records or knowledge of me or my family members' physical or mental health, or any other information bearing on my (our) insurability, to give Lincoln National Life Insurance Company and its reinsurers or any consumer reporting agency acting on the Company's behalf, any such information. This shall include all information about my (our) medical history, diagnosis, treatment, and prognosis including information regarding alcohol and drug abuse. I AUTHORIZE the Insurance Company to have blood sample and urine sample analyzed for the purpose of underwriting my application for insurance coverage. The analysis of the blood and urine sample may include, but is not limited to, tests where allowed by law for diabetes, liver function, kidney disorders, cholesterol and related blood lipids, presence of acquired immune deficiency syndrome antibodies, immune disorders or the presence of medication, drugs or nicotine. I AUTHORIZE the Insurance Company to disclose the results of these tests to the Medical Information Bureau described in the Important Notice. I UNDERSTAND THAT my (our) medical records may be protected by certain Federal Regulations especially as they apply to any drug or alcohol abuse data. I understand that I (we) may revoke this authorization at any time as it pertains to any such drug or alcohol abuse data by written notification; however, any action taken prior to revocation will not be affected. This authorization shall be valid for a period of two years after the date it is signed. A photographic copy of this authorization shall be as valid as the original. I will be given a copy of this authorization at my request. An investigative consumer report may be obtained and if such a report is obtained, I may request to be interviewed in connection with the preparation of that report. If a consumer report is obtained, ___I do, ___I do not request to be interviewed. I ACKNOWLEDGE the receipt of the "Important Notice" containing Fair Credit Report Act and Medical Information Bureau, Inc. information.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health to give to the life insurance companies and companies listed on this form and their reinsurers at the time of my signature any such information. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency utilized by the insurance company to collect and transmit such information. The purpose of this authorization is to determine my eligibility for and apply for insurance products and services from the life insurance companies listed below. I understand that I may refuse to sign this authorization but that if I do refuse to sign, the companies listed below may not be able to fulfill the purpose of this authorization. This authorization shall be valid for 24 months from the date signed below, unless I revoke it, in writing. I understand that I may revoke this authorization at any time by writing to BANYAN LIFE FINANCIAL; however, any action taken in reliance on this authorization prior to the notice of revocation shall be valid. I acknowledge that the information to be disclosed may be protected under state and federal privacy laws and regulations. Once this information is disclosed, it may be subject to redisclosure and no longer covered under those laws and regulations. A photocopy of this authorization shall be as valid as the original, and I understand that I will be given a copy of this authorization. Banyan Life Financial, 21st Services, Advanced Planning Services, Advanced Underwriting Solutions, AIG, American General/U.S. Life, American Viatical Services, LLC, AXA Equitable, Banner, Bedrock Funding LLC, Crump Insurance Services, Bragg, Cambridge Financing Company, Capital Wealth Strategies LLC, CMS, CNA/Valley Forge, Companion Life of NY, Coventry First, Credit Suisse, Empire General, EMSI, F&G Life, Fasano Associates Inc., First Choice Strategies, First Colony, Fortris, General American, Genworth Financial, Genworth Life, Global Life Underwriting, Goldman Sachs, Guardian, Hartford, IMG/ Fox Chase, Indianapolis Life, ING ReliaStar Life, InsCap, Institutional Marketing Concepts, Insurative, ISC Services, Jefferson-Pilot, John Hancock, Landmark Brokerage LLC, Life Insurance Concepts, Life Policy Dynamics LLC, Lincoln Financial, Lincoln Benefit, Longboat Funding LLC, Longmore Capital, Madison One, Mass Mutual, MetLife, Mickelson Capital Consulting, Midwest Medical Review LLC, MONY, Nationwide, New England, New York Life, North American, Pacific Life, Penn Mutual, PFG, Phoenix Life, Presidential Life, Principal, Protective, Prudential, Ridge Capital Group, Secondary Life Capital, Security Connecticut, Security Mutual Life, Sentinel Funding Group LLC, Sentry Financial Services, State Life, Sun Life Financial, The Potomac Group, TransAmerica, Travelers, United of Omaha, Union Central, West Coast Life and Zurich Life. I have received a copy of the Fair Credit Reporting Act Notification and the Exchange of Information (Medical Information Bureau).

I/We understand that Banyan Life Financial has a duty to find the best offer available for my/our life insurance policy(ies). Therefore, I hereby grant to Banyan Life Financial the exclusive right to broker my/our life insurance policy(ies) which may only be terminated upon one-hundred eighty (180) days prior written notice.

Print Proposed Insured Name

Signature

Date