Underwriting Information Questionnaire

Fax to: (317) 876-6290 or email to becky@indytrans.com

Agents Name: ____________________

Email: ____________________ **Phone:** ____________________

Plan Type: ____________________ **Face Amount:** ____________________

Specific Carriers Requested: ____________________

____

Client Name: ____________________ **DOB:** ____________________

Sex: M or F **Height:** __________ **Weight:** ____________________

Has client ever used Tobacco products? YES or NO

Type: __________ **Frequency:** __________ **Last Used:** __________

Last Cholesterol Reading: ________ **Last Blood Pressure Reading:** __________

Has client previously been declined for life insurance? YES or NO

If so, reason for decline? ____________________

____

What companies have you already submitted app to and what were the results? ____________________

____

Family History:

Father: **Living?** _____ **If living, what is his current health?** ______________
Age at Death: _____ **Cause of death:** ____________________

Mother: **Living?** _____ **If living, what is his current health?** ______________
Age at Death: _____ **Cause of death:** ____________________

In the last 5 years has client had a moving violation, reckless driving, DUI/DWI ? YES or NO

If Yes, please explain and give dates: ____

____

Has client ever been diagnosed by a licensed physician as having any of the following conditions?

Alzheimer's Disease	Coronary Artery Disease	Irregular Heartbeat
Alcohol or Drug Abuse	Crohn's Disease	Kidney Disease/ Failure
Aneurysm	Depression/Anxiety	Multiple Sclerosis
Asthma	Epilepsy	Organ Transplant
Cancer	Heart Attack	Parkinson's Disease
Cardiovascular Disease	Hepatitis	Rheumatoid Arthritis
Cirrhosis	High Blood Pressure	Sleep Apnea
COPD (Emphysema)	High Cholesterol	Stroke

Please explain any of the circled items below:

Condition 1: ____________________________________ **Date First Diagnosed:** __________

Please provide treatment, diagnosis, prognosis and medications: _____________

____

____

____

Condition 2: ____________________________________ **Date First Diagnosed:** __________

Please provide treatment, diagnosis, prognosis and medications: _____________

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Condition 3: ____________________________________ **Date First Diagnosed:** __________

Please provide treatment, diagnosis, prognosis and medications: _____________

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AUTHORIZATION

Authorization is HIPAA Compliant

Proposed Insured: ____

Date of Birth: ____________________ Social Security #: ____________________

PURPOSE

The purpose of this Authorization is to permit Driesbach Financial Group, Inc. to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institution ("the Companies") listed on the attachment to this document. Information that may be released to and disclosed by Driesbach Financial Group, Inc. and the Companies listed on the attachment to this document pursuant to this Authorization shall include any and all information, to the extent permitted by applicable law.

INFORMATION TO BE RELEASED

The information to be released pursuant to this Authorization includes any personal health information, records, or data concerning my past, present or future mental, physical or behavioral health or condition ("information"), to the extent permitted by law.

Specifically, information includes all information, records, or data relative to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that this information may include results from blood, saliva, urine and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of: Alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; and HIV infection, including medical test results.

AUTHORIZATION

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information about me to release such information to Driesbach Financial Group, Inc. and its authorized representatives.

I specifically authorize the Companies listed on the attachment to this document to receive information from and to release information to Driesbach Financial Group, Inc. I also specifically authorize Driesbach Financial Group, Inc. and the Companies listed on the attachment to this document to release information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to release information directly to any Company listed on the attachment to this document, upon such insurer's request, provided the insurer is a member of MIB. *

I understand the information disclosed to Driesbach Financial Group, Inc. may have been subject to state and federal privacy laws and regulations. Once information is disclosed to Driesbach Financial Group, Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, Driesbach Financial Group, Inc. or the Companies may not be able to process my request.

I also authorize my Agent, named below, to receive information and I authorize Driesbach Financial Group, Inc. to disclose such information to my Agent, to assist in the purpose of this Authorization, to the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and notice of the revocation is provided to Driesbach Financial Group, Inc., PO Box 68945, Indianapolis, IN 46268. Any action taken in reliance on this Authorization prior to the notice of the revocation shall be valid.

______________________________________ ______________________

Proposed Insured's Signature (or that of the Authorized Representative) Date

____

Print Name of Proposed Insured

____

If signed by Authorized Representative of Proposed Insured, describe authority, e.g. parent or guardian of minor child.

______________________________________ ______________________

Print Name of Agent Date of Expiration

* MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. MIB, Inc., PO Box 105, Essex Station, Boston, MA 02112. Phone: 617-426-3660.

This Authorization is HIPAA Compliant.

Authorized Carriers…

AXA
American General
Banner
Genworth Financial
John Hancock
Lincoln National
Met Life
Prudential
RBC Insurance
Transamerica
United of Omaha
West Coast Life

Proposed Insured: ____

Signature: ____

Date: ________________________________