AGENT SUPPORT GROUP

HEALTH QUESTIONNAIRE

First Name:_________________________ Last Name:___________________________ Date of Birth_____/_____/19_____

Height____________ Weight____________Gain/Loss in the past year______________ US Citizen_____________________ Have you ever used tobacco products: Cigarettes___________________Cigars________________Nicorette________________ If you previously used tobacco, date you quit____

Driver's License #____ State__________________________

All medication(s) you are currently taking dosage(s)____

____

____

Name, address & phone # of your personal physician____

____

____

Approximate date and reason for last visit to personal physician, reason for visit and treatment prescribed______________

____

____

List all specialist(s) you have seen in the past 5 years, type of specialist and for what purpose________________________

____

____

Have you had any hospitalizations or surgeries in the past 10 years (describe)______________________________________

____

____

Have you been diagnosed with cancer or diabetes? Please describe in detail when diagnosed and course of treatment

____

____

Have you been diagnosed with high blood pressure or high cholesterol and if yes, please explain_____________________

____

Within the last 10 years, have you been treated for, or diagnosed as having a heart condition, chest pain, irregular heart rhythm, stroke, cancer, diabetes, ulcer, hepatitis, alcohol abuse or drug dependency?__________________ If yes, please explain

____

____

Within the last 10 years, have you had any illnesses or ailments not described above and if yes, please explain__________

____

Family history: Mother – age if living______ or age at death______Father – age if living_______ or age at death________ Did any of your parents or siblings have a history of diabetes, cancer, stroke or heart disease? If yes, please provide details (i.e., relationship, type of disease, age diagnosed, current age or age at death________________________________

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____

Do you drink alcoholic beverages___________________ If yes, how many drinks per week__________________________

Driving history – have you ever been convicted of DWI or DUI or have you had 2 or more moving violations in the past 10 years? If so, describe in detail____

____

Face amount of insurance desired $___________________________ Type of insurance ____________________________

AGENT SUPPORT GROUP

Authorization for Release of Health-Related Information to Agent Support Group and subsidiaries
This Authorization complies with the HIPAA Privacy Rules

Insured/Patient ____Date of Birth______________________S.S.# __________________________

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize (Agent Support Group) (the “Representative”) and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years (“my Providers”) to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

____ ________________________ ________________________

Proposed Insured’s Signature **Signed and Dated On** **At (City, State, Zip Code)**

Agent / Witness Signature:____

Print Agent / Witness Name: ____

Companies to which this authorization applies to,

21st Century
Advanced Settlements
Allianz Life
Allstate Life of NY
American General
American National
ANICO
AVIVA
AVS
AXA- Equitable
Bankers Life
Banner Life
Berkshire Life & DI
Companion Life of NY
Coventry First
Credit Suisse
Eastport Capital
EMS
Exam One
First Penn
Genworth Financial
Genworth Life & Annuity
General American
Goldman Sachs & Co
Guardian
Hartford Life
Hooper Holmes
Indianapolis Life
Integrity Life
John Hancock
Life Settlements
Lifestyle Settlements
Lifemark Partners
Lincoln Benefit Life
Lincoln Life & Annuity
Lincoln Financial Group
Manulife Bermuda
Mass Mutual
MedAmerican
Mediconnect
Metropolitan Life
Minnesota Life
Mutual of Omaha
National Integrity
Nationwide
New York Life
Northwestern Mutual
Pacific Life
Pan American Life Insurance Group
Parameds.com
Penn Mutual
Phoenix Life
Portamedic
Premium Funding Group
Presidential Life
Principal Life Insurance Co.
Principal National Life Insurance Co
Protective Life
Prudential Financial
ReliaStar ING
RSA Medical
SBLI
Scan Tech Solutions
Securian
Security Mutual
Sun Life
Symetra
Transamerica Life Insurance Co.
Transamerica Financial Life Insurance Co
Union Central
Universal Life Insurance Group.
Universal Underwriters Life Insurance Co.
UNUM
US Financial
US Life
USG Annuity
Welcome Funds
West Coast Life
William Penn
Zurich American Life Insurance Co

Additional Insurance Carrier(s):____ **Insured Initials:**_________________________