Informal Application

Personal Information

Name_____ DOB_____ Gender ☐ Male ☐ Female

Address_____ Are you a US Citizen? ☐ Yes ☐ No

City_____ State_____ Zip _____ If no, country of citizenship _____

Phone#_____ SSN_____ Occupation _____

Marital Status_____ Annual Income $_____ Net Worth $_____

Medical History & Physician Information

Primary Care Physician	City, State & Phone Number	Date Last Seen	Reason for Visit

1. Build: Height _____ft _____in Weight _____lbs

2. In the past 12 months, have you gained or lost more than 10lbs? If yes, how much? _____ gained _____ lost

3. Have you ever had any of the following? If yes, provide details below.

a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke or any other disorder of the heart or blood vessels? ☐ Yes ☐ No

b) Diabetes, elevated blood sugars, glucose intolerance or disease of any gland? ☐ Yes ☐ No

c) Mental or emotional disorder, depression, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? ☐ Yes ☐ No

d) Arthritis, gout or any bone, joint, muscle or skin disorder or skin cancers? ☐ Yes ☐ No

e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder? ☐ Yes ☐ No

f) Hepatitis, ulcer, colitis or other disease of the liver, pancreas, stomach or bowel/colon? ☐ Yes ☐ No

g) Prostate or testicular disease? (Males) ☐ Yes ☐ No

h) Uterine, cervix, ovary or breast disease? (Females) ☐ Yes ☐ No

i) Anemia, leukemia, clotting disorder, platelet or other blood disorder? ☐ Yes ☐ No

j) Urinary tract disorder, kidney, sugar, protein or blood in the urine? ☐ Yes ☐ No

k) Cancer or tumors? ☐ Yes ☐ No

l) Any hospital admission, surgery, emergency room visit or outpatient surgery? ☐ Yes ☐ No

m) Any other health impairment or medical condition related to this risk evaluation? ☐ Yes ☐ No

4. List all medications including over-the-counter and supplements _____

Q#	Additional Physician- Name, City, State & Phone #	Dates Seen & Reason for Visit/Diagnosis	Treatment & Results

Family History

	Current Age	Age at Death	Cause of Death if Applicable	History of Cardiovascular Disease? Provide Detail	History of Cancer? Provide Detail
Mother					
Father					
Brother(s)					
Sister(s)					

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Informal Application

Lifestyle

1. Tobacco/Nicotine

Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, provide frequency and date of last use _____

Have you ever used other products containing tobacco or nicotine? (ex: cigars, pipe, snuff, nicotine gum/patch, e-cigarette)

☐ Yes ☐ No If yes, indicate type, frequency and date of last use _____

2. Marijuana

Do you use marijuana? ☐ Yes ☐ No If yes, indicate frequency and date of last use, check all that apply _____

☐Medicinal ☐Recreational ☐Inhaled ☐Edible ☐Topical ☐Other _____

3. Alcohol

Do you consume alcohol? ☐ Yes ☐ No If yes, provide type, quantity and frequency _____

Has a doctor ever recommended that you decrease your alcohol consumption? ☐ Yes ☐ No

Have you ever received treatment (inpatient or outpatient) for alcohol or drug use?

☐ Yes ☐ No If yes, provide details and dates _____

4. Exercise

Do you exercise regularly? ☐ Yes ☐ No If yes, provide type and frequency _____

5. Driving

Have you had 2 or more moving violations in the last 5 years? ☐ Yes ☐ No If yes, provide details and dates _____

Have you ever received a DUI/DWI? ☐ Yes ☐ No If yes, provide details and dates _____

6. Financial

Have you declared bankruptcy or been convicted of a felony offense in the last 10 years?

☐ Yes ☐ No If yes, provide details and dates _____

7. Hazardous Activity

Are you a private pilot? ☐ Yes ☐ No If yes, do you have an IFR? ☐ Yes ☐ No

Hours flown as pilot in command _____ Hours flown per year _____ Hours anticipated in next 12 mo. _____

Do you participate in any of the following activities? (Check all that apply)

☐Scuba Diving ☐Sky Diving

☐Mountain Climbing ☐Auto/Motorcycle Racing ☐Other _____

Social

List any hobbies, clubs, church or volunteer groups, boards, charities that you are actively involved with:

_____

Travel

Do you travel regularly? If yes, provide frequency, purpose, to which countries and any future travel plans:

_____

Coverage Details

Proposed Coverage Amount $_____ Proposed Plan: ☐ Term ☐ Universal Life ☐ Whole Life

List all inforce coverage below: ☐ Universal Life with LTC ☐ Variable

Carrier	Coverage Amount	Inforce? (Y/N)	Rate Class	Year Issued	To Be Replaced? (Y/N)

Agent Name: _____ **Date:** _____

HIPAA AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

Purpose of Authorization:
The purpose of this authorization is to determine my eligibility for **LIFE INSURANCE PRODUCTS** or related services or conduct other legally permissible activities that relate to any insurance company or service provider listed below.

HIPAA Authorization:
I hereby authorize any licensed physician, medical practitioner, consulting physician, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or other 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 disclose any and all such information regarding diagnosis, treatment, prognosis and consultations to the life insurance companies and servicing agencies listed on this form along with their reinsurers or providers at the time of my signature. Furthermore, I authorize the release of privileged information such as but not limited to alcohol and/or drug treatment, HIV/AIDS treatment and psychiatric records. Treatment, payment, enrollment in a health plan or eligibility for health insurance benefits may not be conditioned on my signing this authorization. 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. I acknowledge that the information to be disclosed may be protected under State and Federal privacy laws and regulations. A photocopy of this authorization shall be as valid as the original. I have received a copy of the Fair Credit Reporting Act Notification and the Exchange of Information (MIB) disclosure. I understand that I may receive a copy of this authorization. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Life Insurance Companies, Servicing Agencies and Writing Agents authorized to receive/transmit information under HIPAA guidelines are: AgencyONE, Allianz, American General Life Insurance/U.S. Life, American National/ANICO, APPS, Arbor Group, Ashar Group, LLC, AXA Equitable/MONY, Banner Life/William Penn, Brighthouse Financial, Cincinnati Life, Coventry, EMSI, Evergreen Settlements,ExamOne, Exceptional Risk Advisors, LLC, Express Imaging Services, Fortamus, Gen Re, Global Atlantic Financial Group, Guardian, Habersham Funding, LLC, IMG Paramed, Inc., Jet Stream, John Hancock, LifeMark Partners, Lincoln Financial Group, Lloyd's of London, LTCI Partners, Mass Mutual, Minnesota Life/Securian Life, Nationwide, New York Life, North American, Ohio National, OneAmerica, Pacific Life Insurance Company, Pacific Life & Annuity Company, Pan-American Assurance Company, Penn Mutual, Principal Life Insurance Co, Principal National Life Insurance Co, Protective Life Brokerage, Protective Life & Annuity, Prudential, Reliastar Life Insurance Company, Reliastar Life Insurance Company of NY, SBLI, Security Life of Denver Insurance Company, Security Mutual Life, Symetra, Transamerica, United of Omaha, Mutual of Omaha, Voya Financial, Welcome Funds, Inc., Zurich Life, Zurich American Life Insurance Company.

***My writing agent,** Robert Trotenberg **, and his/her agency,** Arbor Group **, are also authorized to receive or transmit information under HIPAA guidelines.**

I, the undersigned, hereby authorize any and all medical practitioners, physicians, hospitals, clinics and custodians or anyone else located at:

Medical Facility: _____
Facility Address: _____
Date of Services: _____
Contact Person: _____

To release records and information regarding the Proposed Insured listed below to and exchanged between the parties listed above and:

AgencyONE
11200 Rockville Pike, Suite 500
Rockville, MD 20852
Phone: 301.803.7500
Contact Person: _____

Duration:
Unless otherwise revoked, I agree this authorization shall remain valid for the lifetime of the undersigned, absent any provisions of any applicable state statute or regulations to the contrary, in which event it shall remain valid for 24 months or the maximum period permitted there under. I understand that I may revoke my authorization at any time by submitting in writing request of revocation to: AgencyONE, Chief Underwriter, 11200 Rockville Pike, Suite 500, Rockville, MD 20852. However, any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

_____	_____	_____	_____
Proposed Insured **PRINT**	Proposed Insured **DOB**	Proposed Insured **SIGNATURE**	**DATE**

ARBOR GROUP

Life Insurance Exam Preparation

FOR CLIENT USE

The Life Insurance Exam Process Made Easy

The exam process should not be taken lightly as it can have a **direct impact** on your underwriting offers and life insurance **premium**. There are simple measures you can take to PREPARE your body for the best possible results. In the days leading up to your exam, it is vital that you **HYDRATE** with NON-caffeinated fluids, take all medications as prescribed, and be mindful of your diet. Get plenty of sleep and reduce stress as much as possible. Here are some additional tips:

1. **Morning appointments:** Morning exams are best as people tend to be more relaxed. Stress can falsely elevate blood pressure and pulse rates.
2. **Fasting:** Recommend fasting 12 hours prior to having your blood drawn as non-fasting blood can produce abnormal results on certain tests. Please also drink one large glass of water prior to your appointment since a urine sample will be collected.
3. **Caffeine:** Caffeine is a stimulant that elevates blood pressure and pulse rate. It also dehydrates the body, so please do not consume caffeine prior to your exam.
4. **Alcohol:** Alcohol can affect exam results and should be avoided at least 24 hours prior to your exam.
5. **Salt:** Sodium causes fluid retention which raises blood pressure and can affect blood/urine results. Limit salt intake for several days prior to the exam and stay hydrated.
6. **Smoking:** Smoking cigarettes raises your blood pressure. We advise smokers not to smoke prior to the exam. Be prepared to disclose any cigar, e-cigarette, dip, chew, Nicorette use, etc. with dates. Nicotine testing will occur. If you smoke or consume **MARIJUANA**, it is important you disclose the amount and frequency. Some companies will test for THC.
7. **Exercise: AVOID exercising 48 hours prior to the exam**. Physical activity such as running, jogging, or weightlifting can adversely affect blood and urine results.
8. **Medical History:** It is **VERY IMPORTANT** to give your complete medical history. Be prepared with an accurate list of your doctors' names, addresses, dates visited, diagnoses, and treatments.
9. **Prescription Drugs & Over-The-Counter Medications:** Prepare a complete list of all prescription medications, including those taken only on an "as-needed" basis. Provide dosages, dates prescribed**,** and the prescribing physician's name. Over-the-counter medications including megadose vitamins, Tylenol, supplements**,** and decongestants should also be noted as they may affect blood or urine results.
10. **Urine specimen:** A urine specimen will be collected. You may wish to request that the urine sample be collected at the beginning of the exam process. The most common abnormal finding is protein in the urine, usually resulting from exercise prior to lab testing. See smoking (#6) and exercise (#7) referenced above.
11. **Blood:** Bloodwork will be required. If you are nervous about the blood draw, request this to be completed BEFORE blood pressure and pulse are measured**. *Please refer to *Accessing Your Lab Results On-Line/Authorization to Release* for instructions to retrieve your results*** Please forward the results to your agent upon receipt. These values directly impact underwriting offer(s).
12. **Timing:** Please allow at least 30 minutes for a full exam, perhaps longer if an EKG is involved. A Senior Supplement may be required for clients over the age of 70. Guidelines to help prepare are available upon request.

The underwriting process includes the insurance exam, medical records**,** and potential letters from some of your physicians. Please assist in this process when possible. We are all on the same team! ***REMEMBER, EVERY PHYSICIAN VISIT AFTER THE LIFE INSURANCE EXAM MUST ALSO BE DISCLOSED TO YOUR AGENT AND COULD AFFECT UNDERWRITING DECISIONS.**

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Accessing Your Lab Results

FOR CLIENT USE

Laboratory testing is a vital part of underwriting your life insurance application. ExamOne and Clinical Reference Laboratory (CRL) both offer a secure platform that allows you to access your lab results online.

Why Access My Labs Online?

- Convenience - No paper forms to print and no waiting for your results to be mailed to you.
- Online Availability - Results can be obtained quickly and securely from any internet-enabled device. If your results are still being analyzed at the laboratory, you will have the option to be notified when the information becomes available.
- Flexibility - Once the results are available, you can print or save them for your records and share with your agent and/or personal physician.
- Security - CRL and ExamOne utilize state-of-the-art security measures. Keeping your lab results protected, secure and confidential throughout the process is the top priority.

How Do I Access My Results?

ExamOne	Clinical Reference Laboratory
1. Go to https://applicant.ExamOne.com 2. Click 'Register Here' and include the bar code number from the front of your 'Important Information' brochure. 3. You will receive an email notification when your results become available. 4. Follow the link in the email and login using the username and password. 5. Read and accept the Terms of Use. 6. View, save or print your results!	1. Go to www.AccessMyLab.com and enter your slip ID located on the consent form provided by the examiner. 2. When prompted, enter the last 4 digits of your telephone number. 3. A PIN will be provided via text code or voice message from their automatic system. 4. Enter the PIN to view your lab report online. 5. View, save or print your results!

If you have additional questions on accessing your labs or the life insurance application process, please contact your agent.

Processing times may vary. Please allow up to 10 business days before results become available.

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