

**INFORMAL INQUIRY (CONFIDENTIAL)**  
*Minimum Face amount - \$1,000,000 Permanent, and Term by Exception Only.*

Please note, if you are 80 years of age or older, please complete a [Functional Ability Screening Questionnaire](#).

Full Name		Height & Weight	Social Security #	
Present Address		City	State	Zip
		Daytime Phone		
Date of Birth	Place of Birth	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Tobacco Use Within One Year <input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Cigarettes <input type="checkbox"/> Other	
State of Issue/Ownership	Occupation – Kind of Business – Position			Drivers License #
Proposed Amount of Insurance: \$	Plan: <input type="checkbox"/> Survivorship <input type="checkbox"/> Whole Life <input type="checkbox"/> Variable <input type="checkbox"/> Term <input type="checkbox"/> Single Premium <input type="checkbox"/> Universal Life			Premium Tolerance or Client's Budget:
Community Involvement:				
Charitable Giving:				
Hobbies/Activities				
Net Worth/Income Information:				
Purpose of Insurance:	Business <input type="checkbox"/>	Personal <input type="checkbox"/>	Estate Need <input type="checkbox"/>	Death Benefit Sale <input type="checkbox"/>

Please note, if you are planning to travel outside of the United States please complete a [Foreign Travel Questionnaire](#)

**In-Force Insurance**

Name of Company	Replacement: Yes or No	Death Benefit	Plan	Year Issued	Current Premium	1035 Amount

Have you ever been declined or rated? If so, please explain:	Name of Company	Year	Reason	Rating

**Agent Information:**

Writing Agent		EPS/Region		
Company Name & Address		Broker-Dealer		
City	State	Zip	Daytime Phone	
E-mail		Fax		
One box MUST be checked <input type="checkbox"/> Exclusive with Marsh PCLIS <input type="checkbox"/> Being Shopped		Agents License#		
If being shopped and/or pending application, with whom?				

List of Doctors	Name, Address and Phone #	Date last consulted	Medical problem or reason for visit
Personal Physician:	Name: _____ Address: _____ _____ Phone: _____		
Indicate all other physicians, specialists, clinics or hospitals: (attach a separate page if necessary)	Name: _____ Address: _____ _____ Phone: _____		
	Name: _____ Address: _____ _____ Phone: _____		

Current Medications: \_\_\_\_\_

Have you ever had or are you currently being treated for any of the following conditions?

- |  |   |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Coronary Artery Disease      |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Angina or Heart Attack       |
| <input type="checkbox"/> Diabetes Mellitus   | <input type="checkbox"/> Angioplasty, Stent or Bypass |
| <input type="checkbox"/> Hepatitis B or C    | <input type="checkbox"/> Dementia or Memory Loss      |
| <input type="checkbox"/> Melanoma            | <input type="checkbox"/> Alcohol or Drug Abuse        |
| <input type="checkbox"/> Cancer of _____     |   |

Has anyone in your immediate family (parents or siblings) died before the age of 60? If yes, what was the cause of death? \_\_\_\_\_

Do you participate in any of the following avocations?

- |  |  |
|--|--|
| <input type="checkbox"/> Aviation of any kind      | <input type="checkbox"/> Sky Diving                |
| <input type="checkbox"/> Mountain or Rock Climbing | <input type="checkbox"/> Scuba Diving              |
| <input type="checkbox"/> Extreme Sports            | <input type="checkbox"/> Motorcycle or Auto Racing |

**COPY OF THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.**

## **NOTICE TO THE PROPOSED INSURED**

In connection with your informal inquiry about 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 includes information as to your character, general reputation, personal characteristics and mode of living. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and, if so, 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 to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is POST Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information to their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

**NOTICE OF INFORMATION PRACTICES**

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others such as medical professionals who have treated you. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see a copy, if you wish, of items of personal information about you which appear in the insurance companies' files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

- |                       |                         |                     |
|-----------------------|-------------------------|---------------------|
| AIG Life              | Jefferson Pilot         | Phoenix Life        |
| Allstate Life of NY   | John Hancock            | Principal Financial |
| American General Life | Lincoln Benefit Life    | Protective Life     |
| American Mayflower    | Lincoln National Life   | Reliastar of NY     |
| AXA                   | LSIS                    | Sun Life Assurance  |
| First Colony          | Mass Mutual             | Company of Canada   |
| First Penn Pacific    | Merrill Lynch Life Ins. | The Prudential      |
| GE Life & Annuity     | Met Life Investors      | Transamerica        |
| General American      | Nationwide*             | United of Omaha     |
| Hartford Life         | New York Life           | United States Life  |
| ING                   | Pacific Life            |                     |

For underwriting and claims purposes, I permit:

Any physician or other medical practitioner, hospital, clinic or other medically related facility to give the companies listed above data of a medical nature. This data includes findings on medical care, psychiatric or psychological care or examination, or surgery. I specifically authorize the disclosure to the companies listed above any information concerning sexually transmitted diseases including venereal diseases, any Human Immunodeficiency Virus (HIV) test results, or information about Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, or confidential HIV related information, and any information concerning a serious communicable disease, use of drugs or alcohol and any information concerning mental health.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES PLEASE SEND YOUR REQUEST TO MARSH PRIVATE CLIENT LIFE INSURANCE SERVICES.

\_\_\_\_\_ Signed at \_\_\_\_\_ this \_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_ Day of \_\_\_\_\_ 20\_\_\_\_\_  
Print Name of Proposed Insured



**Marsh Private Client Life Insurance Services**  
**High Net Worth Division**  
 20750 Ventura Boulevard, Suite 310  
 Woodland Hills, CA 91364  
 800 225 9844 Fax 818 710 1475  
 www.secondopin.com

**\*For Authorized Members Only**

**HIPAA AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

**Insured Name:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_ **SSN:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PURPOSE:** For obtaining life insurance

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ or for two years from date of signature.  
 (date)

**REVOCATION:** This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the requester or others have acted in reliance upon this authorization.

**REDISCLASURE:** I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**\*\*FOR OFFICE USE ONLY\*\***

**Name of Dr./Facility:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

\_\_\_\_\_  
 Signature of Proposed Insured or Representative (date)

\_\_\_\_\_  
 Print Name of Proposed Insured or Representative

\_\_\_\_\_  
 Relationship to Insured or Legal Authority -Attach supporting documentation

The section marked **\*\*FOR OFFICE USE ONLY\*\*** will be completed by Marsh Private Client Life Insurance Services and sent to the designated doctors, hospitals, clinics or other medical facilities that appear on the client's informal application. Once the request is sent out for information, the client may request a completed copy of the APS/authorization for his/her files.