BROKERS CLEARING HOUSE LLC.
LIBRA INSURANCE PARTNERS
AN INTEGRITY COMPANY

INFORMAL INQUIRY

Advisor Name: _____ Agency: _____

Phone: _____ Email: _____

APPLICANT INFORMATION

Full Name: _____ DOB: _____ SSN: _____ Sex: ◯ M ◯ F

Address: _____ City/State: _____ ZIP: _____

Height/Weight: _____ Occupation: _____ Drivers License #: _____ US Citizen? ◯Yes ◯No

Annual Income: _____ Net Worth: _____

Purpose of Insurance: _____ Premium Expected: _____

CURRENT AND DESIRED COVERAGE INFORMATION

Amount of Coverage Requested: _____ Type of Coverage: ◯ Term ◯ UL ◯ WL ☐ w/ LTC rider

Owner: _____ Beneficiary: _____

Please list all current coverage - If additional space is needed, please list below in Additional Remarks section.

Company: _____ Face Amount: _____ Issue Year: _____ Cash Value: _____ Replaced: ◯Yes ◯No

Company: _____ Face Amount: _____ Issue Year: _____ Cash Value: _____ Replaced: ◯Yes ◯No

Company: _____ Face Amount: _____ Issue Year: _____ Cash Value: _____ Replaced: ◯Yes ◯No

Company: _____ Face Amount: _____ Issue Year: _____ Cash Value: _____ Replaced: ◯Yes ◯No

Has the Proposed Insured ever been denied, rated or had to postpone any life insurance coverage? If yes, provide date, company, rating, and reason for rating.

_____

_____

MEDICAL BACKGROUND & HISTORY

Please list all physicians seen in the past 5 years. If Additional space is needed, please list below in Additional Remarks section.

Physician Name	Address	Date/Reason for Last Consult	What advice, testing, treatment was completed/prescribed? What were the results?

Please furnish complete details of any "Yes" answers

1. Have you used tobacco or nicotine products in any form? If yes, what type and when was last use? _____

2. Do you currently drink alcohol? If so, what type (beer, wine, liquor)? How often (per day/week)? Have you ever drank substantially more than present? If yes, when? Have you received treatment because of alcohol use? If yes, when? _____

3. Have you ever used illegal drugs or sought treatment because of drug use? If yes, provide details to include type of drugs used, date of last use. Have you or do you currently use marijuana in any form? If so, how often each week? _____

4. Family History of parents and siblings:

	Medical Conditions	Age at Onset/Event	Age if Living	Cause of Death	Age at Death
Father					
Mother					
Siblings					

5. List details for all past and present medications in chart below. If additional space is needed, please list below in Additional Remarks section.

Medication	Dosage/Frequency	Reason for Prescription	Date Last Taken	Prescribing Physician	Physician Contact

IMPAIRMENT QUESTIONS

Has the Proposed Insured ever been diagnosed, treated, tested positive for, or been given medical advice by a medical professional for: (Please give details on "Yes" answers below)

a. Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache) ◯Yes ◯No

b. Any disorder, disease, murmur, heart attack or chest pain, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain) ◯Yes ◯No

c. Any disorder or disease of the respiratory svstem (such as Asthma, bronchitis, emphysema, tuberculosis) ◯Yes ◯No

d. Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs ◯Yes ◯No

e. Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation) ◯Yes ◯No

f. Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles) ◯Yes ◯No

g. Any disorder or disease of the eyes, ears, nose or throat ◯Yes ◯No

h. Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes) ◯Yes ◯No

i. Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive) ◯Yes ◯No

j. Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome) ◯Yes ◯No

k. Any cancer, tumor, cyst or nodule ◯Yes ◯No

l. Any sexually transmitted disorders or diseases ◯Yes ◯No

m. Any disorders of the immune system except those related to the Human Immunodeficiency Virus (AIDS Virus) ◯Yes ◯No

Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Physician Name, Address & Phone

In the past 5 years, has your driver's license been suspended or revoked, been convicted of driving under the influence of drugs or alcohol, or have you been convicted of 2 or more moving violations? If yes, provide details below. ◯Yes ◯No

Have you traveled outside the US or do you plan to travel outside the US in the next 12 months? If yes, provide countries, cities, duration, and purpose of travel.

Have you flown as a pilot or co-pilot in the past 5 years? If yes, provide whether it was for pleasure or business, hours flown in last 12 months, hours expected in next 12 months, total hours flown, licenses held, and type of aircraft flown.

Have you scuba dived or participated in hazardous sports/hobbies in the past 5 years? if yes, provide details (activity, maximum depth, duration, certifications, date last participated, any future activities planned).

Additional Remarks

BROKERS CLEARING HOUSE LLC.
LIBRA INSURANCE PARTNERS
AN INTEGRITY COMPANY

1080 Jordan Creek Parkway, Suite 360N West Des Moines IA 50266
(800) 247-5340 (515) 223-9479 Fax: (515) 224-5948

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Brokers Clearing House (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, including but not limited to the insurance companies listed below 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 Name **Proposed Insured's Signature**

_____ _____
Signed and Dated On **At (City, State, Zip Code)**

Agent/Witness Signature: _____

Print Agent/Witness Name: _____

AllState/NY, Allianz Life, Allianz Life/NY, American Equity, American General Life, American Memorial Life, American National, Americo, Assurity Life, Atlantic Coast, Athene, AXA Equitable, Barnum Financial Group, Brighthouse Financial, Brokers International, Cincinnati Life, Cohen Agency, Companion Life, EquiTrust, Fidelity Security, Forethought Life Insurance, Fortamus, General Re Life Corp, Genworth Life Ins Co, Genworth Life Ins Co of NY, Genworth Life & Annuity Ins Co, Global Atlantic/Accordia, Great American, Great Western, John Hancock USA, John Hancock of NY, Legal & General America/Banner Life/William Penn, Lincoln Financial Group, Lloyds of London, Mass Mutual, Minnesota Life Insurance Company, Mutual of Omaha, National Guardian Life Insurance Company, Nationwide Life Ins Co, New York Life Insurance Company, North American Co for Life & Health, Ohio National, One America, Oxford Life Insurance Co., Pacific Life Insurance Co., Penn Mutual, Principal National Life Co., Principal Life Insurance Co., Protective Life Insurance Co., Prudential Ins Co, Pruco Life Ins Co, Pruco Life Ins Co of NJ, ReliaStar Life Ins Co, ReliaStar/NY, Security Life of Denver, Security Mutual, Symetra, The Guardian, The Life Insurance Center, The Standard, Transamerica, Union Central, United Home Life, United of Omaha, United States Life Insurance Co/NY, VOYA Financial, Wamberg Genomic Advisors, Inc.

Authorization for Release of Information

Proposed Insured's Full Name **Date of Birth** **Social Security Number**

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 5 years ("my Providers") to disclose my entire medical record, prescription history, medications prescribed, 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 my Representative, (Express Imaging Services, Inc) **EIS** and insurance companies and their reinsurers. 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, genetic testing, and psychotherapy notes.

Release From: _____

Facility Name, Provider Name

_____

Address

_____

Phone number

Release To: **EIS Processing Center**
PO BOX 778,
Torrance, CA 90508
Phone # : 888-846-8804
Fax #: 310-320-5031
E-mail: records@ircopy.com

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 **EIS.** I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical 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 and their reinsurers, as well as **EIS,** 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 revoke this authorization and that the revocation will take effect when my 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 understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Signature **Date**