SIMPLICITY ILLINOIS

P 630.869.1651 F 630.869.1654
3400 W Stonegate Blvd, Ste 101-2358 | Arlington Heights, IL 60005

Informal Inquiry

Insured Information

Legal Name (First, Middle, Last): _____

Male ☐ Female ☐

Driver's License #: _____ State: _____ Expiration Date: _____

Height: _____ Weight: _____ Birth State: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ SSN: _____ Email: _____

Employer: _____

Years Employed at Current Job: _____

Tobacco/Nicotine Usage

Have you ever smoked cigarettes? ☐ Yes ☐ No If Yes, date of last usage _____

Have you used other tobacco or nicotine-containing products? ☐ Yes ☐ No

If yes, please provide details:

Agent Information

Name: _____ SNN: _____

Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____

Requested Plan of Insurance

☐ Universal Life ☐ Variable Life ☐ Whole Life ☐ Term, Level Period _____ ☐ Survivorship

Face amount desired $ _____ Premium amount desired $ _____

What is the purpose of insurance?

Inforce Insurance Information

Any Other Life Insurance Inforce? ☐ Yes ☐ No

If So: Replacement: ☐ Yes ☐ No 1035 Exchange: ☐ Yes ☐ No

If yes, please provide estimated amount: _____

Company: _____ Policy Number: _____

Death Benefit: _____ Date Issued: _____

Ownership of Insurance

Owner/If other than Insured: _____

SSN or Tax ID: _____ Date of Birth or Trust Date: _____

Trustee: _____

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Insured: _____

Household Financials

Assets: _____ Liabilities: _____

Liquid Assets: _____ Earned Income: _____

Unearned Income: _____ Household Income: _____

Family History

LIVING OR CAUSE OF DEATH AND AGE

Mother: _____ Father: _____

Siblings: _____

Does any member of your immediate family have a history of: Cancer, Diabetes, Heart Disease? ☐ Yes ☐ No

If yes, please provide details:

Medical History

Date of Last Doctor Visit:_____Doctor's Name: _____

Reason for Last Visit: _____

Please list all physicians seen in the last five years to include reason of visit, diagnosis, medications prescribed:

Please list all current medications:

Have you ever consulted a doctor or received treatment for drug or alcohol abuse? ☐ Yes ☐ No

If so, please provide details:

Do you have a history of coronary artery disease/heart attack/atrial fibrillation? ☐ Yes ☐ No

If yes, please provide details to include date of diagnosis, dates of treatment/surgery and details, Physician treating with contact information:

Do you have a history of cancer of any kind? ☐ Yes ☐ No

If yes, please provide details to include date of diagnosis, type of cancer, stage and grade, physician treating with contact information:

Do you have a history of diabetes? ☐ Yes ☐ No

If yes, please provide details to include date of diagnosis, type of treatment (oral med, insulin), last A1C, any complications, physician treating with contact information:

Please provide details on any other medical condition to include physician treating:

Exam Scheduling

Please provide 3 separate days with times for paramedical exam scheduling:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

☐ 7am-9am ☐ 9am-11am ☐ 11am-1pm ☐ 1pm-3pm ☐ 3pm-5pm ☐ 5pm-7pm ☐ 7pm-9pm

SIMPLICITY ILLINOIS

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number

This form is HIPAA compliant

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Simplicity Illinois, brokers, contractors, employees, representatives and agents working through Simplicity Illinois for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Abacus Life	Fasano Associates, Inc.	Massachusetts Mutual	Prudential Life Ins. Co. / Pruco Life RSA
Advantage Insurance Network, Inc. (AIN)	Fidelity & Guaranty Life Ins. Co.	Metropolitan Life	Medical
Allianz	First Global Financial & Insurance	MetLife Investors USA Insurance Co.	SBLI
American General Life (AIG)	First Insurance Funding	Minnesota Life / Securian Financial	Security Mutual
American National	Foresters	Mutual of Omaha	Standard Life
Americo	General American Life Ins. Co.	National Life of Vermont	Sun Life Ins. Co. of America
Assurity Life	Global Insurance Underwriters	National Western	Sun Life Ins. Co. of Canada
Accordia Life	GE Financial Assurance Co.	Nationwide Life & Annuity Co.	Superior Medical Group
Ameritas	Genworth Life Insurance Co.	New Investor World, Inc.	Symetra
AVS, LLC	Genworth Life and Annuity	New York Life Insurance Co.	Transamerica Life Insurance Co.
AUS Underwriting	Guardian Life Ins. Co.	North American Co.	Travelers Life & Annuity
AXA / MONY / AXA Equitable	Hartford Life Insurance Co.	Old Mutual Financial Network	21st Services
Banner Life	Human API	OneAmerica/State Life	Union Central Life
Beneficial Financial Group	Industrial Alliance Pacific	Pacific Life	United of Omaha
Bragg Associates	ISC Services	Penn Mutual	USG Annuity & Life
Brighthouse Financial	John Hancock Life Ins. Co.	Premium Funding Group (PFG)	Voya - ReliaStar Life of New York
Simplicity Illinois	John Hancock USA	Pioneer Mutual	Voya – ReliaStar
Columbus Life	Lafayette Life	Phoenix Life	Voya – Security Connecticut Life
Concord Capital/INSCAP	Lewis and Ellis, Inc.	Presidential Life	Voya - Security Life of Denver
Coventry First, LLC	Life Insurance of the Southwest	Principal Life Insurance Company	West Coast Life Insurance Co.
Employee Pooling	LifeShare	Principal National Life Insurance Company	Western Reserve Life
Equity Release	Lincoln Financial/ Lincoln Life	Professional Underwriting Services	William Penn Life Ins. Co.
Examination Management Services, Inc.	Lincoln National Life Insurance Co.	Protective Life Ins Co.	Zurich American Life Insurance Company
Additional Insurers and Agencies:			

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____,

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to Simplicity Illinois, the Insurers and Agencies listed afore and to:

Agent/Producer Name: _____.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____ 20 _____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with y our application or informal inquiry concerning 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 would include information as to your character, general reputation; personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, 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 the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may ha ve about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112 , telephone number: 866-692-6901.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse si de will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigativ e consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of info rmation to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.