Insurance Designers Informal Application

Insurance Designers, LLC and it's Partner and Affiliate offices comprise a full service brokerage organization committed to comprehensive insurance analysis for clients. Our on-site underwriting program and informal application process eliminates excess applications, examinations and excessive MIB reports. Learn how you are rated tentatively so you can start with the best potential formal application first!

Instructions

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages. If additional space is needed, use page 4 or add a separate page. Complete, accurate information produces the most competitive carrier offers. Because of the significant expense involved in purchasing medical records, IDA's underwriting staff has final discretion regarding pre-purchase of client's medical records.

If submitting for informal Survivorship quotes, please complete a separate application for each proposed insured and submit together.

1. Broker/Advisor Information

Name ____ Firm/Agency_____________________________________

Phone___________________________ Fax________________________ Email___________________________

2. Case Design Information

Check one; Single Life case Survivorship (complete 2 apps) 1st to Die (complete 2 apps)

Check one) Universal Life Variable Universal Life Whole Life (Term Period) Survivorship UL Other_________________

Death Benefit Amount ____________________________________If no lapse, carry guarantees to age_________

Riders____

Premium design (i.e. lump sum, 1035, limited pay)____

Purpose of Coverage (i.e. estate plan, buy-sell, etc) ____

____

3. Proposed Insured Information

Proposed Insured ____
Last Name First Name MI Daytime Phone

Social Security Number _______-_____-_________ Date of Birth ______________

Drivers License No. _____________________________ State of issue _____________

(Check one)
Male ☐
Female ☐

Residence Address ____
Street City State Zip Code

Employer _____________________________________ Position _________________________________

Duties____ Year in this occupation________

4. Foreign Travel/Citizenship

U.S. citizen? __________ How Long? ___________ If no, country of citizenship ____________________ Dual Citizenship?____

Have you traveled outside North America or Western Europe in the last 2 years or intend to do so in the next 2 years? ___________ If yes, list dates traveled (or anticipated traveling dates), duration, country and purpose of trip on page 4.

INSURANCE DESIGNERS

5. Existing and Pending Insurance

A) Year issued | Company | Amount | Purpose | Keep or Replace?

B) Have you ever been rated substandard, declined or postponed when applying for Life, LTC or DI insurance?
Please include date and explain:

6. Lifestyle and Avocation Information

A) Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years? If yes, hours flown last year ______ Anticipated hours next 12 months _______
License type___________ Date of last flight______ Aircraft type & purpose__________________________________
B) Have you engaged in or plan to engage in scuba or skin diving?
If yes, Number of dives last year______ Anticipated dives next 12 months_________ Maximum depth___________
Where do you dive? (i.e. rivers, open ocean, etc)____
Purpose of diving (i.e. vacation, commercial, instructor)____
C) Have you engaged or plan to engage in any type of motor vehicle or boat racing?
If yes, please provide complete details on license type, circuit, frequency

D) Have you engaged in or do you plan to engage in any mountain climbing, sky diving or any other hazardous sports or activities? If yes, please provide details immediately below or on page 4 if more space is needed.

E) Have you had any moving violations or been cited for driving while impaired?
Please provide details and date of occurrences

F) Have you declared bankruptcy, or been convicted of a felony offense in the last 10 years?
Please provide details

G) Do you use any tobacco or nicotine products presently?
How many years? Type & Amount per day Any plans to quit?

H) Have you ever used tobacco in any form? (check one) cigarettes cigar chew pipe snuff
Date last used Type & Amount per day

J) Do you consume drugs other than prescribed by a physician?
Please provide details

K) Do you consume alcohol? If yes, please specify type, quantity and frequency

L) Have you ever been treated for, or recommended to seek treatment for alcohol or drug abuse?
Please provide details

M) Do you exercise regularly? If yes, please specify type, duration and frequency per week

N) Do you manage your diet? Please explain

7. Medical Information

A) Height Weight Any change greater than 10 pounds in the last 2 years?
If yes, please explain

B) Medications Please list prescription and non– prescription medications used below be sure to include;
Date started Medication & Dosage Purpose Prescribing Doctor's name Results of use

8. Medical Care Providers Information

Please provide complete information for all doctors and health care facilities that have consulted with, or treated you in the last 10 years. If additional space is needed, please continue on page 4 or add a separate page.

Primary Care Physician's

Name_________________________________ Phone # ________________

Address (street)_________________________(city)_________________(State)_____(Zip)_________
Date and purpose & results of last visit

Specialist or other Care Provider ______________________________Phone # __________________

Address (street)_________________________(city)_________________(State)_____(Zip)_________
Date and purpose & results of last visit

Specialist or other Care Provider ______________________________Phone #__ ________________

Address (street)_________________________(city)_________________(State)_____(Zip)_________
Date and purpose & results of last visit

9. Medical Questions

Please provide details (diagnosis, onset date, duration of condition, treatments and current status) to any "Yes" answers on the next page

Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have;

A) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke (TIA), irregular heartbeat or any other disease or disorder of the heart or arteries?
B) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?
C) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
D) Arthritis, gout or any bone, joint, muscle or skin disorder?
E) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
F) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
G) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
H) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
I) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
J) Cancer or tumors of any kind, malignant or benign?
K) Any other health impairment or medically treated condition not yet mentioned?
L) Been advised to seek treatment for any impairment or condition that has not been treated?

General and Medical Question Responses/Details

Please provide the question number and details as appropriate. For Medical questions, Please provide as much detail as possible regarding diagnosis, onset date, duration of condition, treatments, current status and caregiver/ provider with contact information (if different from those listed in section 8.)

Question #	Dates	Details

	AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION This authorization complies with the HIPAA Act and Privacy Rules Page 5

Patient Name ____

Date of Birth _____________________Social Security No.__________________________________
This authorization is for Release of Health-Related Information to the following:

Name____

Address_____________________________City____________________State______Zip_________

My Providers are any health plan physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf. This includes psychotherapy care. My Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; the use of alcohol, drugs, and tobacco; and psychotherapy notes.

I authorize my Providers to disclose my Protected Health Information to the above named company or person(s); their agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I make that restrict my Protected Health Information do not apply to this authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the above named may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4)administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the above named. This authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by doing so in writing and presenting the written revocation to the above named. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to an insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this 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. I further understand that if I refuse to sign this Authorization to release my Protected health Information, the above named may not be able to assist me in processing my application.
I acknowledge that I have received a copy of this Authorization.

Patient or personal representative signature____________________________________ Date____________

Authorized Insurance Carriers

Portamedic & Equifax Services, AIG Life, American General Life Insurance Company, American National Life Insurance Company, Aviva Life and Annuity Company, AXA Advisors/Equitable/MONY Life Insurance Companies, Banner Life, GE Financial/Genworth Companies, Genworth Life Insurance Company, IBU Inc., ING/Security Life of Denver/Reliastar Companies, John Hancock, John Hancock USA, Insurance Designers, Lincoln Benefit Life, Lincoln National Life, Mass Mutual Insurance Companies, Metropolitan Life Companies, Nationwide Financial, New York Life, North American Company for Life and Health Insurance, Pacific Life Insurance Company, Phoenix Life Insurance Company, Principal Financial Group Companies, Protective Life, Prudential Life, Savings Bank Life of MA, Reliance Standard Life, Sun Life of Canada, Transamerica Life Companies, Travelers Life Insurance Company, United of Omaha Life Companies, West Coast Life, Western Reserve Life Insurance, William Penn Life Insurance Company

Notice of Information Practices Provided by Insurance Designers
GIVE THIS PAGE TO THE PROPOSED INSURED

Collection of Information

To underwrite your insurance, information my be collected concerning your age, occupation, physical condition, health history, avocations, or other information necessary to determine appropriate premium rates. The companies listed below may obtain information from medical practitioners or institutions which have provided care to you or your family and from your employers, business associates, friends, neighbors, other insurance companies, the Medical Information Bureau, (MIB), or from an Investigative Consumer Report prepared by an independent reporting firm. If they request such an Investigative Consumer Report, you have the right to ask to be interviewed and, upon written request, to receive the contents of the report from the reporting company. If the report affects your application as requested, they will so notify you and provide you with the name and address of the reporting firm. Further information on the nature and scope of the reports will be provided upon written request to the companies listed below. You may request their address by writing to the address listed on page 5 as authorized recipient of your confidential information.

Medical Information Bureau

The companies listed below will treat information regarding you as confidential. They may make a brief report to the Medical Information Bureau, a non-profit membership organization of the life insurance companies. It operates an information system exchange for its members. The Bureau, upon written request, will give information it may have in its file to a member company: 1) if you apply to a member company for life or health insurance; or 2) if you make a claim for medical benefits. If you send a request to the Bureaus, it will arrange to disclose the information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may seek correction. The address of the Bureau's information office is P.O. Box 105 Essex Station, Boston, MA 02112. The phone number is (617) 426-3660.

Authorized Insurance Carriers

Portamedic & Equifax Services, AIG Life, American General Life Insurance Company, American National Life Insurance Company, Aviva Life and Annuity Company, AXA Advisors/Equitable/MONY Life Insurance Companies, Banner Life, GE Financial/Genworth Companies, Genworth Life Insurance Company, IBU Inc., ING/Security Life of Denver/Reliastar Companies, John Hancock, John Hancock USA, Insurance Designers, Lincoln Benefit Life, Lincoln National Life, Mass Mutual Insurance Companies, Metropolitan Life Companies, Nationwide Financial, New York Life, North American Company for Life and Health Insurance, Pacific Life Insurance Company, Phoenix Life Insurance Company, Principal Financial Group Companies, Protective Life, Prudential Life, Savings Bank Life of MA, Reliance Standard Life, Sun Life of Canada, Transamerica Life Companies, Travelers Life Insurance Company, United of Omaha Life Companies, West Coast Life, Western Reserve Life Insurance, William Penn Life Insurance Company.