# INFORMAL APPLICATION *This form must be submitted with a First Protective HIPAA authorization*

***Date:***

***Agent Name:***

***City & State:*** ***(App Signed)***

## 1. PERSONAL HISTORY

| a. Client's Full Name: Male ☐ Female ☐ | b. DOB | c. Social Security Number | d. Height/Weight | e. Occupation |
|---|---|---|---|---|
| | | | | |

F. Mailing Address including City, State and Zip:

## 2. PRIMARY CARE PROVIDER

| a. Name and Address | | b. Telephone Number |
|---|---|---|
| c. Date Last Seen | d. Reason for Visit | d. Diagnosis |

## 3. MEDICAL HISTORY

List all doctors seen in the last five years:

| DOCTOR NAME /ADDRESS & PHONE | DATE | REASON FOR VISIT | DIAGNOSIS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## 3. ACTION OR TABLE RATING OFFERED BY ANOTHER CARRIER

Have you ever been **declined** or **rated** by an insurance company for coverage? ☐ Yes ☐ No

| Company | Date | Rating/Declined | Reason (please be specific) |
|---|---|---|---|
| | | | |
| | | | |

## 4. REQUESTED INSURANCE *(THIS SECTION MUST BE COMPLETED)*

| Plan: Term ☐ Years? UL ☐ SUL ☐ *(complete separate form for add'l insured)* | 1035 Exchange? ☐ Yes ☐ No | Est. $ Amt: |
|---|---|---|
| Face Amount: | Premium: | Do you have an illustration? ☐ Yes ☐ No *(If "Yes" please provide a copy)* |
| Rate Class Applied for: | Any Riders? (please list) | If First Protective ran illustration, who? |

## 5. MEDICATIONS

List all medications, reasons for medication and dosage currently being taken:

| Name of Medication | Current Dosage | Reason for medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 6. FAMILY HISTORY

| Family Member | Age if Living | Age at Death | Details |
|---|---|---|---|
| ☐ Father | | | |
| ☐ Mother | | | |
| ☐ Siblings | | | |

## 7. FOREIGN TRAVEL

| Where | When | Length of Stay | Details |
|---|---|---|---|
| | | | |
| | | | |

# INFORMAL APPLICATION - Questionnaire Details

*Agent Name:*
*Date:*

*Attach additional copies as needed.*

## PROPOSED INSURED

a. Client's Full Name: | DOB:

## 8. MEDICAL QUESTIONS *(EXPLAIN ANY "YES" ANSWERS USING THE QUESTIONNAIRE DETAILS FORM)*

a. Have you ever had, been treated for, or been medically advised to be treated for, any of the following?

*(for detailed questionnaires for impairments click Life Insurance>Underwriting>XRAE on the First Protective website)*

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No | **Cancer** *(Choose Type)* | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Alcohol Abuse | | | 11. CAD/Heart Attack/Heart Surg. | | | 21. Kidney Disease | | | a. Breast | | |
| 2. Alzheimer's | | | 12. Crohn's Disease | | | 22. Lupus | | | b. Colon | | |
| 3. Anxiety | | | 13. Depression | | | 23. Multiple Sclerosis | | | c. Leukemia | | |
| 4. Arthritis (General/Rheumatoid) | | | 14. Diabetes (Type I or II) | | | 24. Parkinson's | | | d. Lung | | |
| 5. Asthma | | | 15. Drug Abuse | | | 25. Peripheral Vascular Disease | | | e. Lymphoma (Hodgkins) | | |
| 6. Atrial Fibrillation | | | 16. Elevated Liver Functions | | | 26. Sleep Apnea | | | f. Lymphoma (Non-Hodgkins) | | |
| 7. Cerebrovascular Disease | | | 17. Epilepsy/Seizures | | | 27. Stroke | | | g. Ovarian | | |
| 8. Cirrhosis | | | 18. Heart Murmur/Valve Disease | | | 28. Weight Reduction Surgery | | | h. Prostate | | |
| 9. Colitis/Gastritis | | | 19. Hepatitis (Type A, B or C) | | | 29. Sugar, Protein, or Blood in Urine | | | i. Skin | | |
| 10. COPD | | | 20. Irreg. Heartbeat/Palpitations | | | | | | j. Other | | |

b. In addition to the above conditions, in the past 5 years have you: Yes No

(1) Consulted with or received treatment from a care provider or treatment facility?.....

(2) Had an EKG, X-ray or other diagnostic test?.....

(3) Been advised to have any diagnostic test, hospitalization or surgery that was not completed?.....

(4) Had medication prescribed for a physical or mental disorder?.....

c. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family?.....

d. Have you received a DUI or any speeding tickets in the last 3 years?.....

e. Other than prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens or any prescription drugs?.....

f. Do you participate in any aviation, scuba, sky-diving, or any other hazardous sports?.....

g. Mark the one item that best describes your history of **alcoholic beverage** use: **Never Used** **Totally Stopped** **Use Now**

(1) If you have "Totally Stopped," indicate the number of years since you totally stopped and give date & reason in the Questionnaire Details Form

(2) If you "Use Now," how often do you drink alcoholic beverages? **Occasionally** **3 or less days per week** **4 or more days per week**

(3) If you "Use Now," how many drinks do you consume per day? **3 or less** **4-6** **7 or more**

h. Mark the one item that best describes your history of **tobacco** use: **Never Used** **Totally Stopped** **Use Now**

*(1) If you have "Totally Stopped," indicate the type of tobacco used and give the date of last use in the Questionnaire Details Form.*

*(2) If you "Use Now," describe the type* _____ *and amount used* _____.

i. (a) Do you engage in or plan to engage in any **Foreign Travel**? Yes No (b) Do You Reside in a Foreign Country? Yes No

*(1) If "yes" to either question please provide details in Section 7.*

j. Are you a United States citizen? Yes No

## 9. MEDICAL QUESTIONS DETAILS

| Question # | Condition | Duration (M/D/Y to M/D/Y) | Describe Diagnosis, Treatment, Medications, Tests & Results and any additional details *(Provide name and address for any Care Provider/Treatment Facility)* |
|---|---|---|---|
| | | | |
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## 10. ADDITIONAL COMMENTS

# FIRST PROTECTIVE INSURANCE GROUP, INC.
## 600 LUCKIE DRIVE, SUITE 200 • BIRMINGHAM, AL 35223
## 800-876-3950
## AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

1. This authorization to obtain and disclose information complies with HIPAA regulations as they relate to life insurance. I (we) authorize First Protective Insurance Group, Inc. (First Protective) to obtain and use any information about or relating to me (us) that may affect my (our) insurability. First Protective may obtain and use health and medical information, including but not limited to information about drug use, alcohol use, nicotine use, physical and mental diseases and illness, and psychiatric disorders. First Protective may also obtain and use non-health and non-medical information, including but not limited to financial information, credit reports, consumer reports, driving record, criminal record, and information about avocations and aviation activity. All of this information may be used to evaluate an application for insurance. Information relating to communicable diseases and other risk factors relating to me or to my spouse and life partner may be used to evaluate an application for insurance on either me or my spouse and life partner. First Protective's sales agent or regional sales office representing me on my (our) application for insurance may obtain the information described in this paragraph directly from any of the persons or organizations listed in paragraph 2 in order to expedite the delivery of the information to the insurance companies named below.
2. I (we) authorize the following persons and organizations to release and disclose the information described in paragraph 1 to First Protective or its agents acting on its behalf: (i) my (our) doctor(s); (ii) medical practitioners; (iii) pharmacists and Pharmacy Benefit Managers; (iv) medical and related facilities, including hospitals, clinics, facilities run by the Veteran's Administration, Kaiser Permanente, The Cleveland Clinic Foundation and The Mayo Clinic; (v) insurers; (vi) reinsurers; (vii) Medical Information Bureau, Inc. (**MIB**); (viii) my (our) current and previous employers; and (ix) commercial consumer reporting agencies (**CRA**). All of these persons and organizations other than **MIB** may release the information described above to a **CRA** acting for First Protective. **MIB** may not release the information described in paragraph 1 to a **CRA**.
3. I (we) authorize First Protective to release and disclose the information described in paragraphs 1 and 2 to the insurance companies named below, persons or organizations providing services relating to insurance underwriting for First Protective, **MIB**, and as otherwise required by law. First Protective may release and disclose the information described in paragraphs 1 and 2 to other insurers if I (we) have applied or apply to the other insurers for insurance. First Protective may release and disclose the information described in paragraphs 1 and 2 to the sales agent representing me on my (our) application for insurance if it is necessary to provide an explanation of the reasons for First Protective's decision to impose special underwriting requirements, whenever my application cannot be approved as submitted, or in connection with a claim for benefits.
4. This authorization shall be valid for 24 months from the date shown below or, in the event of a claim for benefits, for the duration of such claim.
5. During the evaluation of my (our) insurance application, I (we) understand that I (we) have the right to revoke the authorizations in paragraphs 1 through 4 by writing to First Protective at 600 Luckie Drive, Suite 200 • Birmingham, AL 35223. If this authorization is revoked, this would result in the file being closed and no coverage provided.
6. ☐ (we) have been given a copy of this authorization form.
   ☐ I (we) would like to be interviewed if an investigative consumer report will be made.
   *(Please check the box if you wish to be interviewed if an investigative consumer report will be made.)*
7. I (we) understand that information about me (us) may be disclosed under this authorization to persons or organizations that are not subject to the Health Insurance Portability and Accountability Act **(HIPAA)** and that the information would then no longer be protected by **HIPAA** and any related regulations.
   *I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. Any modifications to this authorization may preclude our ability to process this application.*
8. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

**Date of Authorization:** _____

_____
Proposed Insured 1 (Signature)

_____
Print Name

_____
Proposed Insured 2 (Signature)

_____
Print Name

_____
Parent or Legal Guardian (Signature)
When applicable, print name(s) of minor(s) below:

_____

**Insurance Companies:**
AIG American General
Allianz Life
American National
AVIVA
AXA Equitable
Banner Life
Fidelity Life Associates
Genworth Life insurance Company
Genworth Life and Annuity Insurance Company
Guardian Life
ING USA Annuity & Life
Lincoln Benefit Life
Lincoln Financial
John Hancock NY
John Hancock USA
Mass Mutual
MetLife Investors
Nationwide
New York Life
North American Company for Life and Health
Pac Life
Penn Mutual
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life
Protective Life & Annuity
Prudential Life Insurance Company
Reliastar Corporation
Security Life o fDenver
State Life
Sun Life Assurance of Canada
Transamerica
United of Omaha
William Penn

**THIS AUTHORIZATION MUST BE SIGNED WITHOUT MODIFICATION BEFORE THE APPLICATION CAN BE PROCESSED.**
**PLEASE RETURN THIS AUTHORIZATION WITH THE APPLICATION.**