Informal Inquiry & HIPAA

Windsor Insurance
21820 Burbank Blvd. Suite 100 South
Woodland Hills, CA 91367
Phone: 800.410.9890
Fax: 818.594.5063
newbusiness@windsorinsurance.com

Informal Inquiry

Date: _____

CLIENT: PERSONAL INFORMATION

Name_____ Sex: Male____Female ____

Marital Status: Single ____ Married ____ Divorced ____ Domestic Partner ____

Date of Birth _____

SSN# (last four only) _____ U.S. Citizen: Yes ____ No____

Address _____

City _____ State _____ Zip _____

Office Phone_____ Mobile Phone _____

Email _____

DL # _____ State _____ Height _____ Weight _____

Occupation _____

CLIENT: PERSONAL FINANCIAL INFORMATION

Income Earned: _____ Income Unearned: _____ Net Worth: _____

AGENT/ADVISOR INFORMATION

Agent/Advisor Name _____

Firm Name _____

Office Phone_____ Mobile _____

Email _____

Broker Dealer (if applicable) _____

Life Insurance Questionnaire

Type of insurance you are requesting?

Universal Life ___ Whole Life ___ Variable ___ Survivorship___(UL___VUL___)

Term: Guaranteed Level premium: 10 ___ 15 ___ 20 ___ 30 ___

Face amount desired_____Primary reason for insurance _____

Do you have any other in-force life insurance in place? Yes___ No ___

Total amount in-force_____ Date of last application _____

Are you replacing any insurance? Yes ___ No ___ Face amount replaced _____

Carrier(s) being replaced _____

Do you currently use:

Cigarettes: Yes ___ No ___ If no, and less than 3 years, date last smoked _____

Cigars: Yes ___ No ___ If yes, frequency/quantity_____

Other: Yes ___ No ___ If yes, provide details_____

Have you used THC/CBD in any form within the last 5 yrs? If yes, provide method, frequency, date of last use

_____

Do you have plans to travel or reside outside the US? Yes ___ No ___ If yes, provide dates/details

_____

Have you piloted/flown an aircraft in the past two years? Yes ___ No ___ If yes, hours flown:

in total: _____ in past 12 months _____ expected to fly next year _____

Type of License _____ IFR: Yes ___ No ___

In the past 5 years have you: been in a motor vehicle accident, been charged with a moving violation, DUI or had your license revoked? Yes ___ No ___ If yes, provide dates and details

Have you ever engaged or plan on engaging in: mountain climbing, racing (auto/boat), underwater diving or any hazardous sport or hobby? Yes ___ No ___ If yes, provide dates and details

MEDICAL HISTORY

Primary Physician _____

Address _____ Phone _____

Date of last visit _____ Reason for visit _____

List all other medical specialists that you have seen in the last 5 years.
Include: Name & Specialty / Address / Phone / Date of visit / Reason for visit

_____

_____

_____

_____

_____

List all current medications _____

Have you ever been diagnosed with or treated for any of the following? If yes, provide the number and details.

1. Heart Attack
2. Heart Surgery
3. Heart Disease
4. Chest pain-cardiovascular disease
5. High blood pressure
6. Heart murmur
7. Stroke/TIA
8. Cancer
9. Diabetes (not during pregnancy)
10. Lupus
11. Ulcerative colitis/Crohn's
12. Lung/breathing disorder
13. Kidney disorder
14. Hepatitis/liver disorder
15. Nervous system disorder
16. Brain/spinal cord disorder
17. Depression
18. Alzheimer's or dementia

Other _____

Number	Details
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do your mother, father or sibling(s) have a history of cancer and/or heart disease? If yes, please indicate type of history, date of onset, current age or age at death if deceased.

_____

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN & DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Proposed Insured _____

Date of Birth_____Social Security Number:(last 4 only) _____

Records and Information obtained will be disclosed between the insurance company or companies listed below, and NFP and its subsidiaries, producers, contractors, employees, representatives and affiliates.

INSURERS

AIG Partners Group	Lincoln National Life Insurance Companies	Principal Financial Group
Allianz	Lloyd's of London	Principal Life Insurance Company
American General Life Insurance Company	LTCI Partners	Principal National Life Insurance Company
American National	Mass Mutual	Protective Life Insurance Companies
Americo	Minnesota Life / Securian	Pruco Life Insurance Company
Ameritas	Mutual of Omaha	Prudential Life Insurance Companies
Banner Life	National Life Group	SBLI
Brighthouse Financial	Nationwide Insurance Company	Security Mutual Life of New York
Companion Life	New York Life Insurance Companies	Symetra
ECA Marketing	NFP Insurance Services	Transamerica Life Insurance Companies
Equitable	North American Company	United of Omaha
Fifth Avenue Financial	Pacific Life	US Life
Global Atlantic Financial Group	Pacific Life Lynchburg	William Penn
John Hancock Life Insurance Companies	Penn Mutual	Windsor Insurance Associates, Inc.
Life Insurance Company of the Southwest	Phoenix Home Life	Zurich American Life Insurance Company

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, (5) STD testing and treatment, (6) Genetic testing, (7) Sickle Cell testing and treatment, (8) lab results; (9) other insurance coverage (10) hazardous activities; (11) character; (12) general reputation; (13) mode of living; (14) finances; (15) occupation; and (16) other personal traits.

I understand that any Insurer named above, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect information for proposed insurance coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, Pharmacy Benefits Manager, hospitals, clinics, nurses, records, custodians, or anyone else located at:

Medical Facility Name _____

Address _____ Phone _____

To release any and all records and information regarding the Proposed Insured listed above to and exchanged between the parties listed above and:

Requestor of Medical Information: Windsor Insurance c/o EIS Processing Center

Address: P.O. Box 778, Torrance, CA 90508 / Phone: 888-846-8804 / Fax: 310-320-5031 / Email: records@ircopy.com

Broker/Agent/Agency/Firm Name _____

Broker/Agent/Agency/Firm Address _____

The Insurers named above and their reinsurers will use the information in order to determine whether I am insurable. The insurance producer may also use this information to help update and improve my insurance program.

Those parties named above may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) MIB; or (4) other persons who perform business, professional or insurance tasks for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use a secured internet-based system to store/access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This authorization will remain in effect for 36 months from the date of my signature below. I understand I may revoke this Authorization at any time by requesting such of my broker in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. 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). My authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by their 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 _____ year_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

_____

Signature of Witness _____

Complete if minor child is proposed for coverage: Name of Minor Child _____

Relationship of Representative to minor _____

NOTICE TO PROPOSED INSURED(S)

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

PARTIES TO THE AUTHORIZATION

Windsor Insurance Associates, a brokerage general agency, is an intermediary between your insurance agent and the life insurance company. Windsor Insurance uses approved third party vendors to obtain any medical records required by the insurer during the underwriting process. Express Imaging Services (EIS) is Windsor's vendor of choice. Medical records will be requested from your doctor/facility on your behalf by EIS.

FEDERAL FAIR CREDIT REPORTING ACT NOTICE

Federal law requires that you be advised that in connection with your 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.

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The insurers named on the reverse side or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a 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 of a request from you, the Bureau will arrange disclosure of any information they 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 in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112; Phone (617) 426-366O.

Each named insurer or its reinsurers may also release information in its file 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 INSURANCE INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side 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 investigative consumer report to them. I authorize 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 information 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 REQUIRES THE COMPLETION OF A FULL APPLICATION FOR ITS RESPECTIVE PRODUCT LINES.