INNOVATIVE UNDERWRITERS

1800 JFK Blvd. ■ Suite 700 ■ Philadelphia, PA 19103
(215) 875-8650 (800) 446-7872 FAX: (215) 875-3594

Visit our Web Site: www.innovativeunderwriters.com

INFORMAL INQUIRY

Full Name		Sex (M/F)	Date of Birth	State of Birth
Residence Address		Plan of Insurance WL UL Term___Years		Face Amount $_____
Social Security Number		Approximate Planned Premium $_____		Purpose to Insurance
Beneficiary (name & relationship)		Have you ever used tobacco in any form? Yes ___ No ___ Type_____ Quantity_____ Date of last use_____		
Height: _____ft____ in	Weight: _____ lbs	Any weight loss/gain in past 12 months? _____lbs		
Occupation:	Income: _____ Net Worth: _____	U.S. Citizen? Yes ___ No ___ (If No, complete below) Country of Citizenship_____ Green Card _____ Visa Type_____ Exp. Date_____		
Agent's Name: Phone: E-Mail:		Do you intend to travel outside the US? (Where, How Long, Reason)		

Insurance Information

Have you ever been rated or declined for insurance (with any carrier)? Yes ___ No ___ (If yes, describe below)

Company	Face Amount	Year	Rate Class
1.			
2.			

Please List In-Force or Pending Life Insurance with ALL Carriers (Please include carrier name, face amount, purpose)

Carrier Name	Face Amount	Year	Purpose (Business/Personal)	Replacement? (Y or N)
1.				
2.				
3.				

Physician Listing

Personal Physician:	Address & Phone Number:	Reason & Date last seen
Add itional Physicians Consulted:	Address & Phone Number	Reason & Date last seen
1.		
2.		
3.		

_____

_____

(Attach additional page if necessary)

List any medications you are currently taking:

Medications

Medication	Reason	How Long?

Family History

	Age if Living	Medical History?	Age at Death	Cause of Death
FATHER				
MOTHER				
Siblings				

Aviation/Avocation

Aviation Details:
Private Pilot:____ Commercial Pilot: _____

How many total hours flown? _____

How many hours do you fly per year? _____

Do you have an IFR (Instrument Flight Rating)? Yes or No

Please list any avocations (Scuba Diving, Sky Diving, Rock Climbing, Auto/Motorcycle Racing, Hang Gliding)
See website for questionnaires

Impairment Questions

Diabetes:
- Date of Diagnosis: _____
- Treating Doctor: _____
- Treatment: _____
- Last Hemoglobin A1C with date: _____
- Any Complications?

Cancer:
- Date of Diagnosis: _____
- Type of Cancer: _____
- Stage & Grade: _____
- Type of Treatment: _____
- Date completed treatment: _____
- Treating Doctor: _____

Heart Disease :
- Date of Diagnosis: _____
- Heart Attack: Yes or No
- Results of Catherization (# of vessels, % of blockage): _____
- Angioplasty (dates, which vessels, stent used, etc): _____
- Bypass (dates & results): _____
- Date & results of last stress testing: _____
- Treating Doctor: _____

Drug & Alcohol History:
- Dates of treatment: _____
- Attending AA? _____
- Any DUI or arrests with dates:_____
- Any recurrences with dates: _____

Additional Information:

_____

_____

_____

_____

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HIPAA Authorization

I understand that Innovative Underwriters may need to collect information on me in regard to proposed life insurance coverage. Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish information to Innovative Underwriters, and other insurance companies that may be named below, the types of information specified in this Authorization upon presentation of the Authorization or a photocopy.

The types of information will include records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal traits.

The information will be used by Innovative Underwriters to determine eligibility for insurance, claims, 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, reinsurance companies, or other persons or organizations performing business, professional, or insurance functions for the insurance companies named below, or as may otherwise legally allowed.

This Authorization will be valid for two years after the date of signing. I understand I or my authorized representative has the right to receive a copy of the Authorization.

Signed at _____ this _____ day of _____, 20 _____

Witness_____ Proposed Insured _____

American General/US Life
American National Life
American National Life of NY
Ameritas
Art Jetter & Company
Ashar Group
Assurity Life
AVITAS/Millennium Settlements
AXA-Equitable Life
Banner
Berkshire
Brighthouse
Brighthouse of NY
Columbian Mutual
Companion Life
Fidelity Life
Fidelity Security

First Ameritas Life
First MetLife Investors-NY
Guardian Life
Guarantee Trust Life
IDU Lloyd's
Illinois Mutual Life
ING Reliastar
ING-Reliastar Life of NY
Innovative Underwriters
John Hancock Life
John Hancock USA/NY
Lincoln National Life
Lincoln Life & Ann of NY
Metropolitan Life
MetLife Investors
Minnesota Life

Mutual of Omaha
Nationwide
Nationwide of NY
New York Life
NACOLAH
Pacific Life
Pacific Life of NY
Penn Mutual
Petersen International
Principal National Life
Principal Life
Protective Life
Protective Life of NY
Prudential Life
Reliastar

SBLI
Security Life
Security Life of Denver
Security Mutual Life
Source Brokerage
Symetra
Symetra NY
Transamerica
Transamerica Financial
Union Central Life
United of Omaha
VOYA
William Penn

Read This Important News About HIPAA

The preceding page is a new authorization which complies fully with the HIPAA privacy rules which went into effect on April 14, 2003. For now the HIPAA rules have been applied to health insurance, but most medical offices are not making a distinction and they are requiring this authorization to release records for any insurance purpose. Some medical providers are, in fact, requiring the original signed authorization before they will release medical records.

To make sure your client's informal inquiry goes through smoothly, we request that you:

1. Make several copies of this HIPAA Authorization page.
2. If your client names one attending physician, send us two originally signed authorizations.
3. If your client names four attending physicians, send us five originally signed authorizations.
4. You can FAX us the inquiry form and one HIPAA authorization so we can start on your client's case, but then, please be sure to mail us the originally signed HIPAA authorizations you have collected.

Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others, such as medical professionals who have treated you. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see a copy, if you wish, of items of personal information about you which appear in the insurance companies' files, including information contained in investigative reports. You may also have the right to seek corrections of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES, AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO INNOVATIVE UNDERWRITERS.

Notice to Proposed Insured

In connection with your informal inquiry about 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 includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested and, if so, 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 to the nature and scope of its investigation. You will have the right to inspect a copy of any such report, by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice, or their reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. if you apply to another Bureau member company for life or health insurance coverage, or a claim of 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 it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek correction in accordance with procedures set forth in the Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone: (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information in their files 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.

THE NOTIFICATION APPEARING ABOVE MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE OF THIS FORM

INNOVATIVE UNDERWRITERS

HIPAA Authorization for Release of Health-Related Information

Innovative Underwriters
1800 JFK Blvd., Suite 700
Philadelphia, PA 19103

Phone: (215) 875-8650
Fax: (215) 875-3594

This authorization complies with the HIPAA Privacy Rule

This form MUST be completed and signed along with the inquiry form.
A copy must be left with your client.

Name of Proposed Insured/Patient: _____ Date of Birth _____

Name of Unemancipated Minor _____ Date of Birth _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment,treatment or services to me or on my behalf or to or on the behalf of my unemancipated minor children ("My Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to the company referenced on this authorization ("the Company") and its agents, employees, and representatives. 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 to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is asvalid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 1800 JFK Blvd, Philadelphia, PA 19103, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company(ies) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company(ies) may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

_____
Description of Personal Representative's Authority or Relationship to Patient

SSN of Primary Insured/Patient: _____ SSN of Secondary Insured/Patient: _____

Address: _____ Address: _____

Policy or contract number (if known): _____ Policy or contract number (if known): _____