



Preliminary Inquiry — Not an application for life insurance.

To help you obtain competitive life insurance quotes, please provide information on your medical history, doctors and other factors that may impact underwriting. This preliminary inquiry is not an actual application for insurance and does not guarantee any coverage will be offered. This information is held confidential and released only to parties named below.

PRODUCER INFORMATION

Name	Phone	Email	Producer Number
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Have you submitted this case previously? Yes No

PROPOSED INSURED INFORMATION

Name (First, Last)	Gender	Social Security Number	Date of Birth
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Address	City	State	Zip
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Phone Number	Email Address	Weight	Height	Annual Earned Income	Net Worth
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Occupation:

Is the insured a U.S. citizen? Yes No If no, what is the country of citizenship?

REQUESTED COVERAGE

Proposed Amount of Insurance:	Purpose of Insurance: <input type="checkbox"/> Personal <input type="checkbox"/> Business	Plan: <input type="checkbox"/> Term <input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Survivorship	Type: <input type="checkbox"/> Fixed <input type="checkbox"/> Index <input type="checkbox"/> Variable
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If you are replacing coverage, will there be any 1035 money with this replacement? Yes No If yes, what amount will be carried over?

Will these premiums be financed? Yes No Possibly

Provide details on in-force coverage:

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?

Life Settlements: Indicate any activity in the past five years

Do you have any other pending (or anticipated) applications for life insurance? Yes No

If yes, please provide insurance company name, face amount, date of application:

Have you had a life insurance application declined, rated, postponed, withdrawn, modified, canceled, or not renewed? Yes No

If yes, list date and reason:



Proposed Insured _____

PERSONAL HISTORY

Do you currently drive? Yes No

If yes, provide driver's license number/State:

Driver's License Expiration Date:

Any moving violations in the past 2 years? Yes No

If yes, explain:

Have you ever had your license suspended, restricted or revoked? Yes No

Have you ever been convicted of DWI/DUI? Yes No

If yes, date(s) of DWI/DUI:

Did you lose or gain more than 10 pounds in the past year? Yes No

If yes, explain reason for weight change:

Height: ft in Weight: lbs

Do you engage in regular exercise? Yes No

If yes, list the types of exercise:

Times per week?

How long per occasion?

Do you intend to reside or travel outside of the United States within the next two years? Yes No

If yes, please provide city, country, dates/duration and purpose of all travel:

TOBACCO USE

Have you ever used any form of tobacco or nicotine products? Yes No

If yes, type and quantity used

Cigarettes

Cigars/Cigarillos

Pipe

Smokeless

Vaping

Nicotine delivery systems (including gums, inhalers, lozenges, patches, wafers, etc.)

If yes, are you a current user? Yes No use

If no, date of last use:

Do you use medical marijuana? Yes No

If Yes, what underlying medical condition is being treated?

Is use purely recreational? Yes No

What is the frequency of use? times per (day, week, month, year)

What is the form of consumption / method of use?

Smoking

Vaporizing

Edibles

CBD Oil/CBD Products (IF CBD - does the CBD product/oil contain any THC? Yes No)



Proposed Insured _____

MEDICAL HISTORY

	Doctor's name, address, phone	Date	Illness/Reason
Who is your primary care physician? When did you last consult him/her? Why?			
What other physicians have you consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, or other health facilities have you ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

FAMILY HISTORY

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer?
If yes, provide details below.

Yes No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

DRUG AND ALCOHOL USAGE QUESTIONNAIRE

Do you currently drink alcohol? Yes No

Have you ever used illegal drugs or sought treatment because of drug use?

Yes No

Date of last consumption:

If yes, provide details

Note amounts below:

Type	Amount per week	Type of drug(s) used	Date of last use
Beer			
Wine			
Liquor			

Have you ever consulted a doctor or received treatment because of alcohol use?
 Yes No

Doctor/facility name and address



Proposed Insured _____

CORONARY check here if this section is not applicable

Date of diagnosis or first chest pain _____ Number of diseased vessels _____

Dates/details of treatment/surgery (examples: Angioplasty, Bypass) _____

Date of last stress EKG _____ Results _____ By whom? _____

Any pain since treatment/surgery? _____

CANCER check here if this section is not applicable

Exact type and location of cancer _____ Stage and grade _____

Who would have the pathology report _____ Date/details of treatment/surgery _____

DIABETES check here if this section is not applicable

Date of diagnosis _____ Treatment Diet only Oral medication Insulin _____ Details _____

Do you regularly test your blood glucose? Yes No _____ Results _____ Frequency _____

Latest result of glycohemoglobin (A1C) test _____ mg% _____ Date _____

Have you been diagnosed with having protein and/or microalbumin in your urine? Yes No

Have you ever had: Eye trouble Yes No Heart trouble Yes No High blood pressure Yes No
Kidney trouble Yes No Neuritis/Neuralgia Yes No Insulin reactions Yes No

HAZARDOUS ACTIVITIES check here if this section is not applicable

Are you a private pilot? Yes No How many total hours have you flown as Pilot in Command? _____ How many hours do you fly per year? _____ Do you have an IFR (instrument flight rating)? Yes No
If yes, provide details. _____

Do you participate in the following activities? (check those that apply)

- Scuba Diving
- Bungee Jumping
- Ultralight Flying
- Sky Diving
- Mountain Climbing
- Hang Gliding
- Auto/Motorcycle Racing
- Other

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AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **GBS Insurance and Financial Services, Inc.** (the “Representative”) and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of the next page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years (“my Providers”) to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their reinsurers. 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, prescription drug records and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature on the next page, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of the next page and their reinsurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date signed. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative at 21820 Burbank Boulevard, Suite 301, Woodland Hills, CA 91367 to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured's Name	Proposed Insured's Signature	
Date of Birth	Signed and Dated On	At (City, State, Zip Code)
Agent/Witness Signature: _____		
Print Agent/Witness Name: _____		
I authorize the following provider to release my records: _____		
Physician Name: _____		
Address: _____		

AUTHORIZED RECIPIENTS		
Accordia Life and Annuity Company Allianz Life Insurance Company of North America American General Life Insurance Company/AIG American Memorial Life Insurance Company American National Insurance Companies Ameritas Life Insurance Company Ashar Group Asher Group, LLC Assurity Life Insurance Company AXA/Equitable Banner Life Insurance Company Berkshire Life Insurance Company BPP & Associates, LLC Brighthouse Life Insurance Company Brighthouse Life Insurance Company of NY Cincinnati Life Clear Spring Life and Annuity Insurance Company Companion Life Insurance Company Corebridge Financial Coventry dibrokerWest Diversified Brokerage Services (DBS) EMSI eNoah iSolutions, Inc. Evergreen Exceptional Risk Advisors Express Imaging Services Fidelity and Guarantee Fidelity Security Life Insurance Company Focus 10 Life, Inc. Forethought Life Insurance Company Dr. Robert Frank Genworth Global Atlantic Financial Group	Great American Life Insurance Company Great Western Insurance Company The Guardian Life Insurance Company of America Hanleigh Management, Inc. HCC Specialty Human API Illinois Mutual Life Insurance Company John Hancock LifeCare Assurance Company Life Insurance Company of the Southwest LifeSecure Insurance Company Lincoln Financial Group Mass Mutual MassMutual Ascend Medical Records Now Melville Capital LLC Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates Minnesota Life/Securian Life Mutual of Omaha Insurance Companies Mutual Trust Life Insurance Company National Guardian Life National Life Nationwide Life and Annuity Insurance Company Nationwide Life Insurance Company New York Life North American for Life and Health Oceanview Life and Annuity Company One America Financial Partners, Inc./The State Life Insurance Company Pacific Life & Annuity Company Pacific Life Insurance Company Pan-American Assurance Company	Pan-American Assurance Company International, Inc. Pan-American Life Insurance Company Pan-American Life Insurance Group Peck Financial Penn Mutual Life Peterson International Underwriters PLAN Presidential Life Insurance Company Principal Life Insurance Principal National Life Protective Life Pruco Life Insurance Company Pruco Life Insurance Company of New Jersey Prudential Insurance Company of America RGA Reinsurance Company Rocky Mountain Sagacor Life Insurance Company Security Mutual Life Insurance Company of New York Standard Insurance Company Superior Mobile Medics/Exam One Symetra Life Insurance Company The Savings Bank Life Insurance of Massachusetts Transamerica Insurance & Investment Group United of Omaha Life Insurance Company United States Life Insurance Company in the City of New York Welcome Funds Western National William Penn Life Insurance Company of New York Zurich American Life Insurance Company