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LIFE INSURANCE QUESTIONNAIRE

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**

Have you submitted this case previously? ☐ Yes ☐ No

PROPOSED INSURED INFORMATION

Name (First, Last) | **Gender** | **Social Security Number** | **Date of Birth**

Address | **City** | **State** | **Zip**

Phone Number | **Email Address** | **Weight** | **Height** | **Annual Earned Income** | **Net Worth**

Occupation:

REQUESTED COVERAGE

Proposed Amount of Insurance:

Purpose of Insurance: ☐ Personal ☐ Business

Plan: ☐ Term ☐ Universal Life ☐ Whole Life ☐ Survivorship

Type: ☐ Fixed ☐ Index ☐ Variable

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Have you had a life insurance application declined, rated, postponed, withdrawn, modified, canceled, or not renewed?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:

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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:**

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			

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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

Date of last consumption:

Note amounts below:

Have you ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details

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

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

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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 **If yes, provide details.**	**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

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
Companion Life Insurance Company
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
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
Rocky Mountain
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