INFORMAL INQUIRY

Preliminary Inquiry – Not an application for life insurance. This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier. MUST BE SUBMITTED WITH HIPAA FORM.

PRODUCER INFORMATION (this section must be completed)
Name:
Phone:

PERSONAL HISTORY (this section must be completed)					
Name:			☐Male ☐Female	SSN:	
Address:		City:		State:	Zip:
Date of Birth:	Age:	Height:	Weight:	Monthly Earned Income:	Net Worth:
Occupation:					
Is the client a Foreign National? ☐Yes ☐No			If yes, list country of citizenship		
Has the client traveled outside the United States? ☐Yes ☐No			If yes, list the countries and dates visited		
Green Card? ☐Yes ☐No					
Type of Visa					

GOALS OF THE CASE (this section must be completed)	
What is the ultimate goal of the case?	
What premium is needed to place the case?	
Are you in competition? ☐Yes ☐No	If in competition, with what companies?
Where has the case been shopped and list the outcome?	
Are there any carriers we shouldn't consider?	
Please check if applicable ☐Business Planning ☐Estate Planning ☐Charitable Planning ☐Other _______________________________	
Is your client interested in the following? ☐Annuities ☐Disability Insurance ☐Long Term Insurance (please complete the Disability questionnaire on the website and attach)	

Proposed Insured___________________________________ Social Security Number__________________

REQUESTED COVERAGE (this section must be completed)		
Minimum Consideration: **$500,000 face amount for permanent products** **$750,000 face amount for term products**		☐Universal Life ☐Survivorship ☐Variable Life ☐Whole Life ☐Term, Level Period ____________________
Face amount desired?	Will these premiums be financed? ☐Yes ☐No ☐Possibly	
If you are replacing coverage, will there be any 1035 money with this replacement? ☐Yes ☐No If yes, what amount will be carried over?		

Provide details on pending and in-force coverage:

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

List Settlements: Indicate any activity in the past five years

TOBACCO/NICOTINE USAGE (this section must be completed)

Have you ever smoked cigarettes?

☐Yes ☐No If yes, date of last usage:

Have you used other tobacco containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐Yes ☐No

If yes, provide types and last date of use:

MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your primary care physician? Last consulted? Any ongoing medical treatment?			
What other physicians have you consulted during the past five years? Why? (do not include insurance examinations)			

Proposed Insured___________________________________ Social Security Number__________________

In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities have you ever been treated?		
List all medications, including over-the-counter drugs and vitamins		

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? 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 ☐check here if this section is not applicable

Do you currently drink alcohol? ☐Yes ☐No Date of last consumption:	Do you ever drink substantially more than present? ☐Yes ☐No If yes, when?

Have you ever consulted a doctor or received treatment because of alcohol use?

☐Yes ☐No If yes, provide details____

Type of drug(s) used ____ Date of last use___________________

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

Each name and location of cancer	Stage and grade

Proposed Insured___________________________________ Social Security Number__________________

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
Have you ever had:	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 all that apply) ☐Scuba Diving ☐Bungee Jumping ☐Ultralight Flying ☐Sky Diving ☐Mountain Climbing ☐Hang Climbing ☐Auto/Motorcycle Racing ☐Other__________________________			

DRIVING HISTORY ☐check here if this section is not applicable			
DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Dixon Wells, Inc. (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this 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 re-insurers. 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 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 this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below unless the proposed insured notifies us in writing of their intent to revoke this authorization to the following address Dixon Wells, 2871 Acton Rd Ste 150, Birmingham AL 35243. 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 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**

________________________________ ________________________________
Signed and Dated On **At (City, State, Zip Code)**

Agent/Witness Signature: ____________________________ **Print Agent/Witness Name:** ________________________________

Accordia Life, AIG, Allianz Life, American General Life Insurance Company, American National Insurance Companies, Aviva Life and Annuity, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Financial, Cincinnati Life, Companion Life Insurance Company, Dixon Wells, Express Imaging Services, General Re Life Corp, Genworth Financial Family of Companies, Guardian Life Insurance Company, JetStream, John Hancock, Lincoln National Life Insurance Company, MassMutual Life Insurance Company, Minnesota Life Insurance Company, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, New York Life, North American Company, OneAmerica, Pacific Life, Penn Mutual, Petersen International Underwriters, Principal National Life, Principal Life Insurance, Protective Life Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Savings Bank Life Insurance Company, Security Mutual Life, Security Mutual of New York, Symetra, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, Voya Life Insurance Company, William Penn Life Insurance Company of New York, Zurich Life.