www.naaip.org

Tel: 800.770.0492 email: david@naaip.org

INFORMAL INQUIRY FORM

All questions contained in this questionnaire are strictly confidential and will be part of your medical record.

Name (last, first, M.I.)	Telephone:	DOB:	Height:	Weight:
Address:	City, State, Zip			
Primary Doctor:	Telephone:	Date of last visit:		
Address:	City, State, Zip			
List of Specialists:				
Doctor's Name	Specialty:	Telephone:		
Doctor's Name	Specialty:	Telephone:		

PERSONAL HEALTH HISTORY

Please check the boxes below for all those that apply		**Details of "Yes" Answers**
1. Have ever been treated for or had any indication of:		Include give dates, diagnosis, details and treatment. Be sure to include names and addresses of all attending physicians and medical facilities
a. Disorder of the eyes, ears, nose or throat?	□Yes □ No	
b. Dizziness, fainting, convulsions, headache, speech defect, Paralysis, or stroke, mental or nervous disorder?	□Yes □ No	
c. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	□Yes □ No	
d. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?	□Yes □ No	
e. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder?	□Yes □ No	
f. Sugar, albumin, blood or pus in the urine, venereal disease, nephritis, stone, and or disorder of the kidney, bladder, prostrate or reproductive organs?	□Yes □ No	
g. Diabetes, thyroid, or other endocrine disorder?	□Yes □ No	
h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones?	□Yes □ No	
i. Deformity, lameness, or amputation?	□Yes □ No	
j. Disorder of skin, lymph glands, cyst, tumor, or cancer?	□Yes □ No	
k. Allergies, anemia, or other disorder of the blood?	□Yes □ No	
2. In the past 10 years have you:		
a. Had or been told you have or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?	□Yes □ No	
b. Tested positive for antibodies to AIDS (Human T Cell Lymphotrophic, Type III;HTLV-III) virus?	□Yes □ No	
3. Have you ever:		
a. Used or currently use barbiturates, amphetamines, hallucinogenic drugs (including Marijuana), narcotics, or any prescription drug except in accordance with a physician's instruction?	□Yes □ No	
b. Received counseling advice or treatment regarding the use of alcohol or drugs?	□Yes □ No	
4. Are you currently receiving any medical treatment?	□Yes □ No	
5. Other than in any items already listed, have you, within the past 5 years, been a patient in a clinic, sanitarium, or hospital?	□Yes □ No	
6. Have you ever used tobacco products?	□Yes □ No	
If you quit, when did you stop using tobacco products?	□Yes □ No	
7. Have used any tobacco products in the past 12 months?	□Yes □ No	
8. Do you currently use a nicotine patch or other nicotine product to help stop smoking?	□Yes □ No	

Personal Health History Continued

HEART					
Have you had any of the following:					
High Blood Pressure	□Yes □ No	Last BP Reading:			
High Cholesterol	□Yes □ No	Total Chol. Level:			
History of Chest Pain	□Yes □ No	Evaluated?	□Yes □ No		
Heart Attack	□Yes □ No	No. of attacks:			
Any resulting impairments:					
By-Pass Surgery	□Yes □ No	No. of vessels:	Name of Vessels:	Date:	
Coronary Angioplasty	□Yes □ No	No. of vessels:	Name of Vessels:	Date:	
Stent	□Yes □ No	Which vessels:			
Heart Failure	□Yes □ No	No. of times:	Congestive? □Yes □ No		
Valve Surgery	□Yes □ No	Name of Valve:		Date:	
Pacemaker	□Yes □ No	Type:		Date:	
Atrial Fibrillation:	□ Chronic □ Single Episode				
Premature Ventricular Beats (PVC's)	□Yes □ No	Premature Supraventricular Atrial Beats (PAC's)	□Yes □ No		
Date of last electrogram:	□ Abnormal □ Normal	Attending Physician:			
Where any of the following tests completed:					
Stress Electrocardiogram	□Yes □ No	□ Abnormal □ Normal	Attending Physcian:	Date:	
Echocardiogram	□Yes □ No	Done while exercising?	□Yes □ No	Date:	
Thallium Stress EKG	□Yes □ No		Attending Physician:	Date:	
Coronary Angiogram	□Yes □ No	No. diseased vessels:	Attending Physician:	Date:	

CANCER			
Location of Cancer:		Diagnosis Date:	
Exact name of Cancer:			
Who would have the Pathology report?		Number of adjacent Lymph Nodes with abnormal cells:	
Any radiation or Chemotherapy?	□Yes □ No	Date of last treatment:	
Has there been any reoccurrence of cancer?			
IF skin cancer, was it melanoma?	□Yes □ No	Clarks or Breslows Thickness rating:	
IF prostate cancer:	Gleason Score:	Staging:	
PSA at Diagnosis	Current PSA:	Treatment:	

DIABETES		
Date of diagnosis:	Treatment:	Name of Medication:
Weight 1 yr ago:	Weight now:	Height:
How often are sugar levels monitored?		
Date of last test:	Results:	
Last Hemoglobin A1C reading:	Date:	
Last MicroAlbumin level:	Date:	
Last Glucose Level:	Date:	
Any complications? (e.g. eyes, heart, kidney, etc.)	□Yes □ No	
Details:		

FAMILY HISTORY						
	Age if living	Age at death	History of Cardiovascular Disease	Age of onset	History of Cancer	Age of onset
Father			□Yes □ No		□Yes □ No	
Mother			□Yes □ No		□Yes □ No	
Siblings			□Yes □ No		□Yes □ No	

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	**This form is HIPAA compliant**

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, NAAIP , brokers, contractors, employees, representatives and agents working through NAAIP for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies

Allianz	**First Global Financial & Insurance**	**LifeShare**	**Professional Underwriting Services**
American General Life (AIG)	**First Insurance Funding**	**Lincoln Benefit Life**	**Protective Life Ins Co.**
American National	**First Penn**	**Lincoln Financial/ Lincoln Life**	**Prudential Life Ins. Co. / Pruco Life**
Americo	**Foresters**	**Lincoln National Life Insurance Co.**	**Royal Neighbors of America**
Assurity Life	**General American Life Ins. Co.**	**Massachusetts Mutual**	**RSA Medical**
Aviva / Indianapolis Life	**Global Insurance Underwriters**	**Metropolitan Life**	**Sagicor**
Ameritas	**GE Financial Assurance Co.**	**MetLife Investors USA Insurance Co.**	**SBLI**
AVS, LLC	**Genworth Life Insurance Co.**	**Minnesota Life / Securian**	**Security Mutual**
AUS Underwriting	**Genworth Life and Annuity**	**Mutual of Omaha**	**Standard Life**
AXA / MONY / AXA Equitable	**Guardian Life Ins. Co.**	**National Life of Vermont**	**Sun Life Ins. Co. of America**
Banner Life	**Hartford Life Insurance Co.**	**National Western**	**Sun Life Ins. Co. of Canada**
Beneficial Financial Group	**Industrial Alliance Pacific**	**Nationwide Life & Annuity Co.**	**Superior Medical Group**
Bragg Associates	**ING - ReliaStar Life of New York**	**New Investor World, Inc.**	**Symetra**
Broker's Alliance	**ING – ReliaStar**	**New York Life Insurance Co.**	**Transamerica Life Insurance Co.**
Columbus Life	**ING – Security Connecticut Life**	**North American Co.**	**Travelers Life & Annuity**
Concord Capital/INSCAP	**ING - Security Life of Denver**	**Old Mutual Financial Network**	**21st Services**
Edison Risk, LLC	**ISC Services**	**One America/State Life**	**Union Central Life**
Equity Key, LLC	**John Hancock Life Ins. Co.**	**Pacific Life**	**United of Omaha**
Equity Release	**John Hancock USA**	**Penn Mutual**	**USG Annuity & Life**
Examination Management	**Kestler Financial**	**Premium Funding Group (PFG)**	**West Coast Life Insurance Co.**
Services, Inc.	**Lafayette Life**	**Pioneer Mutual**	**Western Reserve Life**
Fasano Associates, Inc.	**Lewis and Ellis, Inc.**	**Phoenix Life**	**William Penn Life Ins. Co.**
First Choice Brokerage	**Life Distributors of America, LLC**	**Presidential Life**	**Zurich American Life Insurance Company**
Fidelity & Guaranty Life Ins. Co.	**Life Insurance of the Southwest**	**Principal Life Insurance Company**	
		Principal National Life Insurance Company	

Additional Insurers and Agencies:

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____,
any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to NAAIP , the Insurers and Agencies listed afore and to:
Agent/Producer Name:_____.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance 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, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

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). If minor children are proposed for coverage, the above statements are made by the 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 _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X_____Printed Name: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

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

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.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

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. This also authorizes 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 REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.