



## Davis Life Brokerage

Your Financial Services Partner...*For Life!*

3737 Woodland Avenue, Suite 600

West Des Moines, Iowa 50266

www.DavisLife.com 800-747-5612 dlb@DavisLife.com

# Preliminary Underwriting Questionnaire and Authorization Information and Instructions

Thank you for taking the time to complete the following pages. It is our goal to get the best possible offer for your client. In order to do that we need to have the most current health and lifestyle information regarding the proposed insured. After all pages have been completed and signed, please fax them to:

**Attention: New Business**

**Fax Number: 888-618-7444**

Please allow 48 hours for someone to contact you regarding this case.

### Submitting Agent Information

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Ext \_\_\_\_\_

Address \_\_\_\_\_ Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Fax \_\_\_\_\_ E-mail \_\_\_\_\_

Are you shopping this case? YES NO

If YES, what companies have you submitted or are you going to submit this case to? \_\_\_\_\_

Based on your client's history what offer are you expecting? \_\_\_\_\_

What is the best way to contact you? \_\_\_\_\_

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# Preliminary Underwriting Questionnaire

Please take a few moments to complete all sections of this questionnaire.

We will be better able to help if we have the most current and accurate information possible.

## Section 1...Proposed Insured Information

Full Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Place of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_

SSN/Tax ID Number \_\_\_\_\_ Employer & Occupation \_\_\_\_\_

Home Address \_\_\_\_\_ Unit/Apt \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Driver's License Number \_\_\_\_\_ License State \_\_\_\_\_

US Citizen \_\_\_\_\_ If No, Date of Entry \_\_\_\_\_ Type of Visa \_\_\_\_\_

## Section 2...Current and Desired Coverage Information

Amount of Coverage Requested \_\_\_\_\_ Type of Coverage \_\_\_\_\_ Term \_\_\_\_\_ UL \_\_\_\_\_ WL \_\_\_\_\_

Owner \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Annual Income \_\_\_\_\_ Net Worth \_\_\_\_\_

Please List All Current Coverage

Company \_\_\_\_\_ Face Amount \_\_\_\_\_ Issue Year \_\_\_\_\_ Cash Value \_\_\_\_\_

Will This Policy Be Replaced \_\_\_\_\_

Company \_\_\_\_\_ Face Amount \_\_\_\_\_ Issue Year \_\_\_\_\_ Cash Value \_\_\_\_\_

Will This Policy Be Replaced \_\_\_\_\_

Company \_\_\_\_\_ Face Amount \_\_\_\_\_ Issue Year \_\_\_\_\_ Cash Value \_\_\_\_\_

Will This Policy Be Replaced \_\_\_\_\_

Has the Proposed Insured ever been denied, rated or had to postpone any life insurance coverage? \_\_\_\_\_

If yes, please complete the information below

Company \_\_\_\_\_ Rated / Declined / Postponed \_\_\_\_\_ Year \_\_\_\_\_

Reason \_\_\_\_\_

Company \_\_\_\_\_ Rated / Declined / Postponed \_\_\_\_\_ Year \_\_\_\_\_

Reason \_\_\_\_\_

Company \_\_\_\_\_ Rated / Declined / Postponed \_\_\_\_\_ Year \_\_\_\_\_

Reason \_\_\_\_\_

## Section 3...Medical History

Please circle Yes or No for all questions.

If yes answer applies to any questions, please provide details, such as: date of first diagnosis, name and address of doctor, test performed, test results, medication(s) recommended, and any treatment information in the area provided.

1. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:
  - A. Heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? **YES NO**
  - B. A blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? **YES NO**
  - C. Cancer, tumors, masses, cysts or other such abnormalities? **YES NO**
  - D. Diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system? **YES NO**
  - E. Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestines? **YES NO**
  - F. A disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? **YES NO**
  - G. Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder? **YES NO**
  - H. Seizures, a disorder of the brain or spinal cord, or other nervous system abnormality including a mental or nervous disorder? **YES NO**
  - I. Arthritis, muscle disorder, connective tissue disease or other bone or joint disorders? **YES NO**

2. Has the Proposed Insured in the past three years had but not sought treatment for:
  - A. Fainting spells, nervous disorder, headaches, convulsions or paralysis **YES NO**
  - B. Any pain or discomfort in the chest or shortness of breath? **YES NO**
  - C. Disorders of the stomach, intestines, or rectum or blood in the urine? **YES NO**

3. What is the Proposed Insured's height \_\_\_\_\_ Weight \_\_\_\_\_

4. Is the Proposed Insured currently under treatment, therapy, or medical observation? **YES NO**  
If YES, Please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Please list all medications and dosages \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain any questions answered YES above \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Section 4...Lifestyle Information

1. Has the Proposed Insured used tobacco of any form in the past 24 months? **YES NO**  
If YES, please list date of last nicotine use\_\_\_\_\_ Type of Tobacco\_\_\_\_\_  
Are you currently using nicotine gum or patch? **YES NO**
2. Has the Proposed Insured ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? **YES NO**
3. Has the Proposed Insured ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? **YES NO**  
**If YES is answered to questions 2 or 3, please complete a Drug/Alcohol Questionnaire**
4. Does the Proposed Insured engage in regular physical exercise other than which occurs during their work? **YES NO**  
Type of exercise \_\_\_\_\_ Number of times each week \_\_\_\_\_ For how many minutes \_\_\_\_\_  
\_\_\_\_\_
5. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among the Proposed Insured's parents or siblings? **YES NO**  

	Age, if living	Health	Age at Death	Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
Brother/Sister	_____	_____	_____	_____
6. In the past three years, has the Proposed Insured been in a motor vehicle accident, been charged with a moving violation, or had their license restricted or revoked? **YES NO**  
If YES, please explain\_\_\_\_\_
7. Does the Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? **YES NO**  
If YES, please list country, date, length of stay and purpose\_\_\_\_\_

## Section 5...Physician Contact Information

Applicant's Personal Physician \_\_\_\_\_ Telephone \_\_\_\_\_  
Name of Clinic \_\_\_\_\_  
Address \_\_\_\_\_ Suite \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Last Visit \_\_\_\_\_  
Reason for visit? \_\_\_\_\_

Please list any other physicians, clinics, hospitals, or sanitariums the Proposed Insured has consulted with or been a patient of within the last five years on a separate piece of paper.

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## HIPAA AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**DURATION:** This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ or two years from date of signature.  
(Date)

**EVOCAATION:** This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

**REDISCLASURE:** I understand that the Requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

**PURPOSE:** To obtain life insurance.

\_\_\_\_\_  
Signature of Proposed Insured or Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Proposed Insured or Representative

\_\_\_\_\_  
Relationship to Insured

\_\_\_\_\_  
or Legal Authority  
Attach supporting documentation

**Authorization to Obtain Information  
 Waiver and Acknowledgment Form**

**AUTHORIZATION:**

I AUTHORIZE \_\_\_\_\_, OR any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Davis Life Brokerage 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 signing below. I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so the Davis Life Brokerage may: 1) underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below.

AIG Life Insurance Company	Allianz Life Insurance Company of North America	American General Life Insurance Company
American National Insurance Company	Assurity Life Insurance Company	Aviva Life and Annuity Insurance Company
Aviva Life and Annuity Company of New York	AXA Equitable Life Insurance Company	Banner Life Insurance Company
Columbus Life Insurance Company	Genworth Life and Annuity Insurance	ING Life Insurance and Annuity Company
John Hancock Life Insurance	Lincoln Benefit Life Company	Lincoln National Life Insurance Company
Life Insurance Company of the Southwest	Metropolitan Life Insurance Company	Midland National Life Insurance Company
New York Life Insurance Company	North American Company for Life and Health	OM Financial Life Insurance Company
Phoenix Life and Annuity Company	Presidential Life Insurance Company	Principal Life Insurance Company
Protective Insurance Company of America	Reliastar Life Insurance Company	Shenandoah Life Insurance Company
Standard Life and Accident Insurance Company	Sun Life Assurance Company of California	Transamerica Occidental Life Insurance Company
United of Omaha Life Insurance Company	West Coast Life Insurance Company	Innovative Underwriting Solutions
Other:		

This authorization shall remain in force for 24 months, beginning \_\_\_\_\_. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above named facility or Davis Life Brokerage, 801 Ashworth Road, West Des Moines, IA 50265. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

# WAIVER AND ACKNOWLEDGMENT

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (th "Applicant") in favor of Davis Life Brokerage, its successors, assigns, shareholders, directors and employees (collectively "Davis Life Brokerage").

Applicant acknowledges, understands and agrees as follows:

- \* that Applicant has filed an application with Davis Life Brokerage intending to secure life insurance from one or more insurance underwriters.
- \* that, in the course of applying for life insurance coverage, Davis Life Brokerage has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- \* that Davis Life Brokerage will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representative.
- \* that Davis Life Brokerage maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- \* that Davis Life Brokerage will use the Interchange to store some or all of the confidential and personal information Applicant has provided to Davis Life Brokerage, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- \* that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- \* that, even though Davis Life Brokerage has in place security measures Davis Life Brokerage believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though Davis Life Brokerage will continue to upgrade those security measures from time to time as circumstances warrant, Davis Life Brokerage can make no guarantee as to Davis Life Brokerage's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
- \* that Davis Life Brokerage cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
- \* that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in Davis Life Brokerage's possession and/or stored on the Interchange.
- \* that Applicant will indemnify Davis Life Brokerage for all costs and expenses incurred by Davis Life Brokerage or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I have received a copy of this document.

I AGREE this form shall be valid for twenty-four (24) months from the date shown below.

Signed on this date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

X \_\_\_\_\_  
Signature of Proposed Insured/Parent or Guardian

X \_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Printed name of Proposed Insured/Parent or Guardian

HIPAA Privacy Rule compliant