ISSUE INSURANCE AGENCY INC.
Since 1972
We Get Better Offers!

407 Corporate Center Dr, Ste A, Vandalia, Oh 45377
Phone Number: 1(800)762-7500
Fax Number: 1(937)890-1909
Website: www.issueins.com

PRELIMINARY INQUIRY - NOT AN APPLIATION FOR LIFE INSURANCE

This Preliminary Inquiry form may be used to gather 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.

PERSONAL HISTORY (THIS SECTION MUST BE COMPLETED)

Client Name______________________________ ☐ Male, ☐ Female

Social Security #______________________________,

Address______________________ City______________ State________ Zip________

Date of Birth________________ Age________ Height________ Weight________

Monthly Earned Income $____________________

Occupation ______________________________

US Citizen: ☐ Yes ☐ No (Details:______________________________)

Tobacco/Nicotine Usage

1. Have you ever smoked cigarettes: ☐ Yes, ☐ No If yes, date of last usage: ____________________
2. Have you used other tobacco or nicotine containing products: ☐ Yes, ☐ No

(Tobacco type: ☐ cigars, ☐ pipe, ☐ snuff, ☐ nicotine gum or patch ☐ Other ____________________)

If yes, provide types and last date of use:______________________________

AGENT INFORMATION (THIS SECTION MUST BE COMPLETED)

Name ______________________________ Soc. Sec #________________

ISSUE Agent ID____________________ Phone #____________________

Address ______________________ City______________ State________ Zip________

Fax #____________________ Email Address ______________________________

REQUESTED PLAN OF INSURANCE (THIS SECTION MUST BE COMPLETED)

Face amount desired: $__________ **Premium amount desired:**$__________ ☐ Annually, ☐ SA, ☐ Monthly

1035 lump sum: $____________ Non-1035 lump sum: $____________ Pay premiums until: __________

Type: ☐ Universal Life, ☐ Whole Life, ☐ Survivorship, Term (☐ 5-yr, ☐ 10-yr, ☐ 15-yr, ☐ 20-yr, ☐ 25-yr, ☐ 30-yr)

Riders: ☐ Waiver of Premium, ☐ Addional insured rider, ☐ Child Rider (________ units), __ Other: (____________)

What will be the purpose of the insurance?______________________________

***For Survivorship Life**, please have other proposed insured submit a Preliminary Inquiry form as well.*

PROVIDE DETAILS ON PENDING AND IN-FORCE COVERAGE:

Company	Policy / Application Date	Amount	Class/Rating Issued	Current Premium	Replacing?
					YES NO
					YES NO
					YES NO
					YES NO

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MEDICAL HISTORY (THIS SECTION MUST BE COMPLETED)

Primary Physician	Doctor's name, address & telephone #	Date of last consult	Illness

What other physicians have you consulted during the **past five years**? (*Do not include insurance examinations.*)

In what hospitals, clinics, or other health facilities have you ever been treated?

Please list all current medications.

FAMILY HISTORY (THIS SECTION MUST BE COMPLETED)

Have any family members (parents/siblings) been diagnosed or died from heart disease or cancer before age 60?

__ Yes __ No, If yes, please provide the following details:

Relationship	Diagnosis	Age of disease onset	Age at death
☐ Mother, ☐ Father, ☐ Brother, ☐ Sister			
☐ Mother, ☐ Father, ☐ Brother, ☐ Sister			
☐ Mother, ☐ Father, ☐ Brother, ☐ Sister			

DRIVING RECORD (THIS SECTION MUST BE COMPLETED)

______ Tickets in last 24 months Type: details______________________________

______ Tickets in last 60 months Type: details______________________________

Have you ever had license suspended or revoked?

Details:

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DRUG AND ALCOHOL USAGE

☐ CHECK HERE IF THIS SECTION IS NOT APPLICABLE

Do you currently drink alcohol?
☐ Yes ☐ No
Date of last consumption:________________
Note amount below.

Type:	Amount per week:
Beer	
Wine	
Liquor	

Did you ever drink substantially more than present?
☐ Yes ☐No
If yes, when?________________
Note amount below.

Type:	Amount per week:
Beer	
Wine	
Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use? ☐ Yes ☐ No
Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No
If yes, provide date(s): ________________

____

Have you ever sought medical treatment because of drug use or has drug use ever been a problem?
☐ Yes ☐ No If yes, provide details:
Types of drug(s) used:________________
Date of last use:________________

CORONARY ARTERY DISEASE

☐ CHECK HERE IF THIS SECTION IS NOT APPLICABLE

Dates / details of treatment / surgery: ☐ **Angioplasty,** ☐ **Bypass,** ☐ **Stent,** ☐ **Valve Replaced,** ☐ **Other** ________
Date of diagnosis or first chest pain: ________-________-________
Date(s) and number(s) of Heart Attack(s): ________________
Number of diseased vessels additional detail:________________

____

Date of last stress EKG: ________-________-________
Results:________________
By whom?________________
Any pain since treatment/surgery?________________

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CANCER

☐ CHECK HERE IF THIS SECTION IS NOT APPLICABLE

Exact name and location of cancer:____

____

Stage and grade:____

____

Who would have the pathology report?____

____

Dates / details of treatment (include date 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 RESULTS OF GLYCOHEMOGLOBIN (A1C) TEST: _________mg% Date: ________-________-________

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

Have you EVER had:

a. any eye trouble? ☐ Yes ☐ No
d. kidney trouble? ☐ Yes ☐ No
b. heart trouble? ☐ Yes ☐ No
e. neuritis/neuralgia? ☐ Yes ☐ No
c. high blood pressure? ☐ Yes ☐ No
f. 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 below.

How many total hours have you flown as Pilot in Command? ____

How many hours do you fly per yer? ____

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, ☐ Ulralight / Hang Gliding, ☐ Sky Diving, ☐ Mountain Climbing, ☐ Auto/Motorcycle Racing

Have you traveled outside the US in the last 5 years or do you plan to travel outside the US in the next 5 years?

Details:

ALL PAGES OF THIS PRELIMINARY INQUIRY FORM MUST BE COMPLETED.

INQUIRY CAN'T BE CONSIDERED UNLESS AUTHORIZATION (ATTACHED) IS SIGNED BY PROPOSED INSURED.

HIPAA Compliant Authorization to Release Confidential Information

Proposed Insured: ______________________________ DOB: _____________ Social Security #________________

Purpose:
The purpose of this Authorization is to permit ISSUE Insurance Agency to obtain and release nonpublic information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the Companies") listed on the reverse of this document. Information that may be released to and disclosed by ISSUE Insurance Agency and the Companies listed on the reverse of this document pursuant to this authorization shall include any and all information, to the extent permitted by applicable law.

Information to be Released:
The information to be release pursuant to this Authorization includes any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or condition ("Information"), to the extent permitted by law.

Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that this information may include results from blood, saliva, urine and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical test results.

Authorization:
I authorize any physician or other medical practitioner, any hospital, clinic or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information about me to release such Information to ISSUE Insurance Agency, and its authorized representatives.

I specifically authorize the Companies listed on the reverse of this document to receive information from and release information to ISSUE Insurance Agency. I also specifically authorize ISSUE Insurance Agency and the Companies listed on the reverse of this document to release Information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to release Information directly to any Company listed on the reverse of this document, upon such insurer's request, provided the insurer is a member of MIB.

I understand that Information disclosed to ISSUE Insurance Agency may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to ISSUE Insurance Agency, it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, ISSUE Insurance Agency or the Companies may not be able to process my request.

I also authorize my Agent, named below, to receive Information and I authorize ISSUE Insurance Agency to disclose information to my Agent, to assist in the purpose of the Authorization to the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to ISSUE Insurance Agency at 407 Corporate Center Dr., Suite A, Vandalia, Ohio 45377. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

____ ____________________
Proposed Insured's Signature (or that of Authorized Representative) Date

______________________________________ ______________________________________
Print Name of Proposed Insured Print Name of Agent

____
If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask it to correct the information as provided in the Federal Fair Credit Reporting Act. You can write to MIB, Inc., P.O. Box 105, Essex Station, Boston MA 02112 of call 1(617) 426-3660.

ISSUE INSURANCE AGENCY INC.

HIPAA Compliant Authorization to Release Confidential Information

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB, as a part of our underwriting process we or one of the insurance companies listed below may request an investigative consumer information report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or others with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is a normally conducted, but you are entitled to make a specific request. We keep such information reports confidential and use them only to evaluate and underwrite your application.

You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to safeguard the information we have.

We may disclose personal information about you without prior authorization under certain circumstances. For example, we may disclose information about you to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. We may give information to accounting firm performing audits, governmental agencies reviewing our practices or attorneys hired to protect our legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which you have applied for coverage or benefits. Information may be furnished your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law.

We may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which you may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured lives.

No medical record information or personal information relating to your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

You Can View and Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell is in writing, and we will include your statement when we give your information to anyone outside of ISSUE Insurance Agency.

Proposed Insured Signature: ______________________________ Date: ____________________

Print Name: ______________________________ Social Security #: ______________________

Allianz Life Ins. Co.	Foresters Financial	Lloyd's of London (and affiliates)	Principal Financial Group
American General life Ins. Co.	Fidelity Security Life Ins. Co	MetLife Investors / MetLife Ins. Co.	Prudential Insurance / PRUCO
American General Life of NY	First American Ins Underwriters	Minnesota Life	Savings Bank Life Ins.
American National Ins. Co.	Genworth Life & Annuity Ins. Co.	Mutual of Omaha / United of Omaha	Reserve National Life Ins Co.
American United Life Ins. Co.	Genworth Life Ins. Co. of NY	Nationwide	Standard (Ins Co of Oregon)
Assurity Life Ins. Co.	Gerber Life Ins. Co.	North American Co. Life & Health	Symetra Life Ins Co.
AVIVA Life Ins. Co. (Athene)	Gleaner Life Ins. Co.	Northwestern Mutual.	State Life Insurance Co.
AXA Financial Life	Global Atlantic Financial Group	New York Life	The Marketing Alliance
Berkshire Life	Guarantee Trust Life Ins. Co.	Ohio National Life Ins. Co.	Transamerica Life Ins. Co.
Brighthouse Financial Ins. Co.	ING Life.	One America Financial Partners	United Farm Family Life Ins Co.
Cincinnati Life Ins Co	John Hancock Life Ins. Co.	One Resource Group	United Home Life Ins Co.
Columbus Life / Western & Southern.	Legal & General America (Banner)	Pacific Life	Voya Financial
Companion Life Ins. Co.	Lincoln Financial Group	Petersen International Underwriters	Wilson Brokerage Services