INFORMAL APPLICATION

Date

Agent

City & State

This form must be submitted with a **compliant** HIPAA authorization

1. PERSONAL HISTORY

a. Client's Full Name: Male Female	b. DOB	c. Social Security Number	d. Height/Weight	e. Occupation

f. Mailing Address include City, State and Zip:

g. DL# & State

2. PRIMARY CARE PHYSICIAN

a. Name and Address		b. Telephone Number
c. Date Last Seen	d. Reason for Visit	e. Diagnosis

3. MEDICAL HISTORY

List all doctors seen in the last five years:

DOCTOR NAME /ADDRESS & PHONE	DATE	REASON FOR VISIT	DIAGNOSIS

4. ACTION OR TABLE RATING OFFERED BY ANOTHER CARRIER

Have you ever been declined or rated by an insurance company for coverage? Yes No

Company	Date	Rating/Declined	Reason (please be specific)

5. REQUESTED INSURANCE (THIS SECTION MUST BE COMPLETED)

Plan: Term Years? UL SUL (complete separate form for add'l insured)		1035 Exchange? Yes No	Est. $ Amt:
Face Amount:	Anticipated Premium:	Do you have an illustration? Yes No *(If "Yes" please provide a copy)*	
Rate Class Applied for:		Any Riders? (please list)	

6. MEDICATIONS

List all medications, reasons for medication and dosage currently being taken:

Name of Medication	Current Dosage	Reason for medication

7. FAMILY HISTORY

Family Member	Age if Living	Age at Death	Details
Father			
Mother			
Siblings			

8. FOREIGN TRAVEL

Where	When	Length of Stay	Details

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Agent
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Questionnaire Details - Attach additional copies as needed

a. Client's Full Name: DOB:

9. MEDICAL QUESTIONS (EXPLAIN ANY "YES" ANSWERS USING THE 'MEDICAL QUESTION DETAILS' BOX AT BOTTOM OF PAGE)

a. Have you ever had, been treated for, or been medically advised to be treated for, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Cancer *(Choose Type)*	Yes	No
1. Alcohol Abuse			11. CAD/Heart Attack/Heart Surg.			21. Kidney Disease			a. Breast		
2. Alzheimer's			12. Crohn's Disease			22. Lupus			b. Colon		
3. Anxiety			13. Depression			23. Multiple Sclerosis			c. Leukemia		
4. Arthritis (General/Rheumatoid)			14. Diabetes (Type I or II)			24. Parkinson's			d. Lung		
5. Asthma			15. Drug Abuse			25. Peripheral Vascular Disease			e. Lymphoma (Hodgkins)		
6. Atrial Fibrillation			16. Elevated Liver Functions			26. Sleep Apnea			f. Lymphoma (Non-Hodgkins)		
7. Cerebrovascular Disease			17. Epilepsy/Seizures			27. Stroke			g. Ovarian		
8. Cirrhosis			18. Heart Murmur/Valve Disease			28. Weight Reduction Surgery			h. Prostate		
9. Colitis/Gastritis			19. Hepatitis (Type A, B or C)			29. Sugar, Protein, or Blood in Urine			i. Skin		
10. COPD			20. Irreg. Heartbeat/Palpitations						j. Other		

b. In addition to the above conditions, in the past 5 years have you: Yes No

(1) Consulted with or received treatment from a care provider or treatment facility?........

(2) Had an EKG, X-ray or other diagnostic test?........

(3) Been advised to have any diagnostic test, hospitalization or surgery that was not completed?........

(4) Had medication prescribed for a physical or mental disorder?........

c. Is there a history of diabetes, cancer, high blood pressure, heart, kidney disease, alcoholism, mental illness, or suicide in your family?......

d. Have you received a DUI or any speeding tickets in the last 3 years?........

e. Other than prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens or any prescription drugs?........

f. Do you participate in any aviation, scuba, skydiving, or any other hazardous sports?........

g. Mark the one item that best describes your history of alcoholic beverage use: Never Used Totally Stopped Use Now

(1) If you have "Totally Stopped," indicate the number of years since you totally stopped and give date & reason in the Question Details box below

(2) If you "Use Now," how often do you drink alcoholic beverages? Occasionally 3 or less days per week 4 or more days per week

(3) If you "Use Now," how many drinks do you consume per day? 3 or less 4-6 7 or more

h. Mark the one item that best describes your history of tobacco use: Never Used Totally Stopped Use Now

(1) If you have "Totally Stopped," indicate the type of tobacco used and give the date of last use in the Medical Question Details box below.

(2) If you "Use Now," describe the type ______________________ and amount used ______________________

i. (1) Do you engage in or plan to engage in any Foreign Travel? Yes No (2) Do You Reside in a Foreign Country? Yes No

(a) If "yes" to either question please provide details in Section 8 on first page.

j. Are you a United States citizen? Yes No

k. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation? Yes No

Please list details to any Yes answers below:

10. QUESTION DETAILS

Question #	Condition	Duration (M/D/Y to M/D/Y)	Describe Diagnosis, Treatment, Medications, Tests & Results and any additional details (Provide name and address for any Care Provider/Treatment Facility)

11. ADDITIONAL COMMENTS OR DETAILS

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Milner Financial, its affiliated agencies, including but not limited to Verisk Health/Mediconnect, Parameds.com, EMSI, Jetstream, ExamOne, and ProScan Partners ______________________________ ,hereby referred to as "my agent", to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, the Department of Motor Vehicles, or other health care provider that has provided treatment or services to me or on my behalf within the past 20 years ("my Providers") to disclose my entire driving and medical records 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 my agent and its staff, affiliated companies and/or entities, including but not limited to Verisk Health/ Mediconnect, Parameds.com, JetstreamAPS, 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 driving and 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 driving and medical records without restriction to Milner Financial. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

In furtherance of my above acknowledgments regarding release of my driving and medical records and any associated HIPAA protected health information and in an effort to process my application in an efficient and timely manner, I hereby authorize Milner Financial to use my below signature on any and all HIPAA authorizations to my health care providers required to underwrite and/or process the life insurance application submitted through the above referenced agent. I understand that I can revoke use of my signature at any time. In exchange for use of my signature on any required HIPAA authorizations, Milner Financial will send me a copy of all such authorizations.

Check for Acknowledgment

The information contained in these driving, 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 below and their reinsurers as well as Milner FInancial and its staff; employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. 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 my agent or Milner Financial at PO Box 491090 Lawrenceville, GA 30049, to revoke this authorization and that the revocation will take effect when my agent 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 understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Milner Financial 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 Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

____
Proposed Insured's Name

____
Proposed Insured's Signature

____
Signed and Dated On

____
At (City, State, Zip Code)

Agent/ Witness ______________________________

American General/ AIG
American National
Americo
Ameritas
Assurity
Accordia Life
AXA/Equitable
Banner/LGA

Cincinnati Life
Coventry
EMSI
ExamOne
General RE Life Corp
Guardian
Habersham Funding
Human API

ING/Reliastar/SLD
BU
John Hancock
Life Ins. Settlements, Inc
Life of the Southwest
Lincoln National
Lloyd's of London
Mass Mutual

Minnesota Life
National Life Group
NACOLAH
Nationwide
NewYork Life
One America
PAC Life
PennMutual

Principal Life Ins. Co.
Principal Nat'l Life
ProScan Partners
Protective Life
Prudential
Sagicor
SBLI

Securian
Symetra
Transamerica
Union Central
United of Omaha
Welcome Funds
Zurich