INFORMAL INQUIRY

Not an application for life insurance

Important: Please complete all sections prior to submission. Incomplete information will result in inaccurate assessments from insurance carriers.

PRODUCER INFORMATION

Producer: ______________________________ Date: ______________________________

Face Amount: ______________________________ Product: ______________________________

PROPOSED INSURED INFORMATION

Applicant Name: ______________________________ ☐ Male ☐ Female DOB: ____________

SS#: ______________________________ Drivers License #: ______________________________

Street Address: ______________________________

City: ______________________ State: ______________________ Zip Code: ____________

Primary Phone Number: ______________________________ ☐ Home ☐ Work ☐ Mobile

Alternate Phone Number : ______________________________ ☐ Home ☐ Work ☐ Mobile

Occupation: ______________________________ Income: ______________________________

Assets: ____________ Liabilities: ______________________ Net Worth: ______________________

Premium Tolerance/Offer needed to place: ______________________________

Can you provide Third Party Financials signed by a currently licensed CPA? ☐ Yes ☐ No

INSURANCE CURRENTLY IN FORCE

Company	Year Issued	Face Amount	Being Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

ACTIVITY AND MEDICAL INFORMATION

Do you participate in any hazardous activities? ☐ Flying ☐ Scuba ☐ Climbing ☐ Other

Details: ______________________________

Do you have any plans for foreign travel? ☐ Yes ☐ No

Details: ______________________________

Have you ever used any kind of tobacco product? ☐ Yes ☐ No

Forms Used: ☐ Cigarette ☐ Pipe ☐ Gum ☐ Patch ☐ Cigar ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other ____________

Date last used: ______________________________

Do you have any knowledge that an application or informal inquiry has been seen by any carrier in the last year?

☐ Yes

☐ No

Company	Offer	Placed?

Height: ______________________ Weight: ______________________

ACTIVITY AND MEDICAL INFORMATION, CONTINUED

Do you have a history of:

High Blood Pressure ☐ Yes ☐ No

Heart Condition/Coronary Artery Disease ☐ Yes ☐ No

☐ Heart Attack ☐ Bypass Surgery Date of event: ______________________

☐ Stent(s) Date of Last EKG/Stress Test: ______________________

Diabetes ☐ Yes ☐ No

At what age were you diagnosed? ______________________

List all diabetes medications currently prescribed:

Medication: ______________________ Dosage: ______________________

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Medication: ______________________ Dosage: ______________________

Most recent A1c level: ____________ Current glucose reading: ______________________

Respiratory Disease ☐ Yes ☐ No

Have you been hospitalized for this condition: ☐ Yes ☐ No

Have you been diagnosed with sleep apnea? ☐ Yes ☐ No

Are you curently using a CPAP? ☐ Yes ☐ No

Date of last pulonary function test: ______________________

Cancer ☐ Yes ☐ No

Type of cancer: ______________________

Was there a biopsy? ☐ Yes ☐ No Cancer stage if known: ____________

Date of surgery, if any? ______________________

Date of completion of radition treatment: ______________________

Date of competion of chemotherapy: ______________________

Please list any medical conditions not indicated above: ______________________

____

____

FAMILY MEDICAL HISTORY

Family Member	Age If deceased, age @ death and cause	History of Heart Disease?		History of Cancer?		Type
Mother		☐ Yes	☐ No	☐ Yes	☐ No	
Father		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 1		☐ Yes	☐ No	☐ Yes	☐ No	
Sibling 2		☐ Yes	☐ No	☐ Yes	☐ No	

SENIOR SUPPLEMENT

Have you been diagnosed with Alzheimer's or dementia? ☐ Yes ☐ No

Have you ever been treated for memory problems? ☐ Yes ☐ No

Do you require assistance for walking? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Do you exercise on a daily basis? ☐ Yes ☐ No

Do you require assistance with daily chores? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever been diagnosed with depression? ☐ Yes ☐ No

Have you ever been diagnosed with anemia? ☐ Yes ☐ No

Please provide details of any "Yes" answers above: ______________________

____

SENIOR SUPPLEMENT, CONTINUED

Please list all medications being taken: ______________________________

____

PHYSICIAN INFORMATION

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________

PHYSICIAN INFORMATION, CONTINUED

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________

Physician Name: ______________________ Phone: ______________

Address: ______________________________

Date last seen: __________ Reason: ______________________

ADDITIONAL NOTES

ROCKY MOUNTAIN INSURANCE NETWORK
9200 West Cross Drive, Suite 508, Littleton, Colorado 80123 ■ 303-839-1431 ■ 800-846-3997 ■ FAX 303-832-6417

Patient Name: ____ Date of Birth: ____________

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations, and the representatives of these companies may need to collect information on me in regard to proposed life insurance coverage.

Allianz
American General
American National
AXA Equitable
Brighthouse Financial
Global Atlantic
Illinois Mutual
John Hancock
Lincoln National
MetLife
Minnesota Life
Mutual of Omaha
Nationwide
New York Life
North American
OneAmerica
Principal Life Insurance
Principal National Life
Protective
Prudential
Rocky Mountain Insurance
Securian Financial
Standard Insurance Company
Symetra
Transamerica Life Insurance Co.
United of Omaha
Zurich

I authorize any health plan, physician, dental practitioner, health care professional, hospital, client, laboratory, Pharmacy, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 10 years to disclose my entire medical records and any other protected health information. This includes information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illnesses and the use of alcohol, drugs, and tobacco and includes psychotherapy notes.

I understand that authorizing disclosure of health information is voluntary. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility to obtain benefits. I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and addressed to the privacy officer of the above named facility authorized to make this disclosure. I understand that the revocation does not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire in six months or on the following date:
____

I understand that any disclosure of information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I need not sign this authorization to assure treatment. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact the privacy officer at the facility listed above that is authorized to disclose this information and request a copy of this authorization.

THIS INFORMATION WILL BE RELEASED UNLESS YOU INITIAL HERE: DO NOT RELEASE_____________

____ ___________________________

Signature of Proposed Insured or Authorized Representative **Date (MM/DD/YYYY)**