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

PRELIMINARY INQUIRY (CONFIDENTIAL)

Date: _____ Agent: _____ State: _____

Phone: (____) _____ Email Address: _____

Proposed Insured's Full Name:	Sex:	Date of Birth:	Height & Weight:

Present Address:	Social Security Number:

Any Tobacco Use Within Five Years? Yes ____ No ____ Type: Date of Last Use:	Rating on Current Policy:

Face Amount: **($1M Min)**	Plan: _____Term _____Permanent _____Survivorship

Health Issues: please give as much information as possible regarding this case (the condition, medications they are taking, date of diagnosis etc)

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This Authorization complies with the HIPAA Privacy Rules

Authorization for Release of Health Related Information

Please disclose the following protected health information to: Rocky Mountain Insurance Network Inc. and Jet Stream Copy Service.
(Please Print Clearly)

Patient Name: _____ Date of Birth _____

Social Security Number: _____

1.) Doctor/Medical Facility: _____

Address: _____

_____ Phone: (_____)_____

2.) Doctor/Medical Facility: _____

Address: _____

_____ Phone: (_____)_____

3.) Doctor/Medical Facility: _____

Address: _____

_____ Phone: (_____)_____

4.) Doctor/Medical Facility: _____

Address: _____

_____ Phone: (_____)_____

5.) Doctor/Medical Facility: _____

Address: _____

_____ Phone: (_____)_____

PLEASE NOTE: Obtaining medical records may take up to 3 to 4 weeks.

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

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)**