**INFORMAL INQUIRY**

*Not an application for life insurance*

Himmelstein Financial

*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: _____

Medication: _____ Dosage: _____

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<br>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**

## Authorization to Obtain and Disclose Protected Health Information (PHI)

This form is intended to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. It authorizes the insurance agent named below, acting on behalf of [Insert Affiliate Name], to collect and share medical information for the limited purpose of underwriting and placing life, disability, or long-term care insurance coverage.

### Proposed Insured Information

Proposed Insured's Name: _____

Date of Birth: _____ Last 4 Digits of SSN: _____

### Purpose of This Authorization

I authorize the release and disclosure of my Protected Health Information ("PHI") to the insurance agent named below and [Insert Affiliate Name]. This information will be used solely for the purpose of evaluating, underwriting, or placing insurance coverage on my behalf.

### Information to Be Released

This authorization applies to all relevant medical records and personal information, including but not limited to:

- Medical history, diagnosis, treatment, and prognosis
- Physician and hospital records, laboratory reports, and test results
- Prescription drug history
- Mental health records (excluding psychotherapy notes)
- Alcohol and substance-use treatment records
- HIV/AIDS-related information (where permitted by law)
- Sexually transmitted diseases
- Sickle Cell testing or treatment
- Other information relevant to my insurability

### Authorized Recipients

My information may be disclosed to and used by the following parties:

- The insurance agent named below and Himmelstein Insurance Brokerage
  Life insurance companies, reinsurers, and insurance support organizations involved in evaluating or placing coverage
- The Medical Information Bureau (MIB, Inc.), when applicable
- Third-party service providers assisting in retrieval or secure transmission of information (e.g., Human API, ExamOne, or similar)

Authorized Insurers, Reinsurers, and Service Providers:

21st Services
Abacus Life
Advantage Insurance Network (AIN)
Accordia Life (Global Atlantic)
Allianz
American General Life Insurance Co.
American National
Americo
Ameritas
Apeiron Gate
Assurity Life
AUS Underwriting
AVS, LLC
Banner Life
Brighthouse Financial
Columbus Life
Coventry First, LLC
DigitalOwl, Inc.
Employee Pooling
Equitable
ExamOne (Quest Diagnostics)
Fidelity & Guaranty Life (F&G)
Foresters
Global Insurance Underwriters
Guardian Life Insurance Company
Human API
ISC Services
JetStream Medical Records Retrieval
John Hancock Life Insurance Company
John Hancock USA
Lafayette Life
Lewis and Ellis, Inc.
Life Insurance of the Southwest
Lincoln Financial / Lincoln National
Massachusetts Mutual
Minnesota Life / Securian Financial
Mutual of Omaha
National Life of Vermont
Nationwide Life & Annuity
New York Life Insurance Company
North American Co. for Life and Health
Northwestern Mutual

OneAmerica / State Life
Pacific Life
Penn Mutual
Premium Funding Group (PFG)
Principal Life Insurance Company
Principal National Life Insurance Co.
Protective Life Insurance Company
Prudential / Pruco Life
Risk Righter
SBLI
Security Mutual Life
Standard Insurance Company
Standard Life Insurance Co of NY
Symetra
Transamerica Life Insurance Company
United of Omaha
United States Life Insurance Company
William Penn Life Insurance Company

## Redisclosure Notice

I understand that once my information is disclosed under this authorization, it may be re-disclosed by the recipient and may no longer be protected by federal privacy laws. However, all parties receiving my information agree to use it solely for the purposes stated in this authorization and to comply with all applicable privacy laws.

## Privacy Responsibility

Himmelstein Insurance Brokerage is the entity responsible for safeguarding my PHI and for any required notices under HIPAA.

**Right to Refuse or Revoke Authorization**

I understand that I am not required to sign this authorization. However, if I choose not to sign, the insurers and agencies involved may be unable to evaluate or issue insurance coverage. I may revoke this authorization at any time by providing written notice to my insurance agent or to the Privacy Officer of [Insert Affiliate Name]. Revocation will not apply to disclosures made in reliance on this authorization before it was revoked.

**Expiration of Authorization**

This authorization will remain valid for 24 months from the date signed below, unless I revoke it earlier in writing or a longer period is required by applicable state law.

**Acknowledgment and Copy**

I understand that a copy or electronic version of this authorization shall be as valid as the original. I am entitled to receive a copy of this signed authorization. My healthcare providers will not condition treatment, payment, enrollment, or benefits eligibility on whether I sign this authorization.

**Signature and Authorization**

Signed at _____ on this _____ day of _____, 20____

Signature of Proposed Insured / Authorized Representative: _____

Printed Name: _____

Relationship (if signed by a representative): _____

**Insurance Agent Information**

Insurance Agent Name: _____

Phone: _____

**Privacy Officer Contact**

Privacy Officer:

Himmelstein Insurance Brokerage
17 Mountain Avenue
Bloomfield, CT 06002
Email: paul@himmelsteinfinancial.com

**Notice to Proposed Insured**
This notice is provided in connection with your authorization to release information for insurance underwriting purposes. It explains your rights under federal and state privacy laws, including the Fair Credit Reporting Act (FCRA), and outlines the information practices of insurers, insurance support organizations, and their representatives. This document is not an application for insurance.

**Federal Fair Credit Reporting Act (FCRA) Notice**

In connection with your application or informal inquiry for life, disability, or long-term care insurance, an investigative consumer report may be prepared. This report may include information obtained through interviews with your personal and professional associates, as well as other sources concerning your character, general reputation, personal characteristics, and mode of living. You have the right to be informed whether such a report has been requested, and if so, the name and address of the consumer reporting agency that prepared it. You also have the right to request a copy of the report and to dispute or correct any inaccurate information.

**MIB, Inc. Notice**

MIB, Inc. (formerly the Medical Information Bureau) is a nonprofit membership organization of life and health insurance companies that operates an information exchange for its members. Information about your medical history or other factors affecting your insurability may be shared with MIB and may be disclosed to member companies if you apply for insurance in the future. MIB information is used only as an alert to the possible need for further investigation and cannot be used as the sole basis for an underwriting decision.
You have the right to access and correct any information that MIB may have on file about you. To exercise this right, contact MIB, Inc. at:

MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184
Telephone: 866-692-6901
Website: www.mib.com

**Notice of Insurance Information Practices**

In the course of properly underwriting and administering your insurance coverage, insurers and their representatives may collect personal information about you from a variety of sources, including:

- Information provided by you or on your behalf
- Medical professionals and facilities that have treated you
- Other insurance companies or insurance support organizations
- Consumer reporting agencies or public records

This information may be shared with reinsurers, insurers, and other entities performing business or professional services for them. You have the right to be told about, and to see and copy, any personal information that appears in their files, and to request correction of any information you believe to be inaccurate, subject to applicable law.

**Important Notice**

This notice is provided for your information and does not obligate you to purchase insurance. You are encouraged to retain a copy of this notice for your records. If you have questions regarding this notice, please contact your insurance agent.