



Baker Associates

8444 N. 90th Street, Suite 110
Scottsdale, AZ 85258
480.538.1004
888.899.6599
www.bakco.com

Preliminary Inquiry (Confidential)

Name	SSN	Sex	Place of Birth	Birth Date	Hgt. & Wgt.
Present Address					
Occupation (Type of business, position, how long)			Tobacco use within last 5 years – <input type="checkbox"/> Yes Cigar, Cigarettes, Pipe or Chew <input type="checkbox"/> No		Last Date Used
Amount	Plan: <input type="checkbox"/> Term _____ <input type="checkbox"/> Permanent <input type="checkbox"/> Survivorship				
INSURANCE IN-FORCE	Is this for Replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Have you ever been: <input type="checkbox"/> Declined? <input type="checkbox"/> Rated?	Give Details:			
PENDING TRIALS/APPLICATIONS			PREMIUM TOLERANCE		
Has case been shopped? Is Trial or Formal application pending or being contemplated with any Insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of Company and offer received?			What premium can be placed? What rating is needed to place the case?		
PRELIMINARY HEALTH AND FAMILY HISTORY	Current medications		1.	2.	
			3.	5.	
	Physician last consulted:	Date	Name, Address and Telephone Number		Reason for visit, Medical Problem/History
	Physicians consulted during past 5 years:				
	In what Clinics, Hospitals or Mental Health facilities have you ever been treated?				
	Family History: Has any immediate family member (parent, brother or sister) had heart disease, diabetes, cancer, high blood pressure or kidney disease?				
	What is the client's most significant medical problem?				
	Any other medical problems?				
	Is there anything else the underwriter should know?				

FOREIGN TRAVEL	Do you intend to travel or reside outside of the U.S. or Canada within the next two years? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list country, date, length of stay and purpose.			
		Date	Country	Length of Stay	Purpose <input type="checkbox"/> Business <input type="checkbox"/> Personal
AVOCATIONS (SPORTS, AVIATION, SCUBA DIVING)	Do you participate in extreme sports or other hazardous activities? <input type="checkbox"/> Yes <input type="checkbox"/> No (Examples are: auto racing, scuba diving, aviation, cave exploration, sky diving, hang gliding, parachute jumping, mountain or rock climbing, boat racing, hydroplane racing, etc.)				
	Do you participate in any flights as a trainee, pilot or crew member? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you certified? <input type="checkbox"/> Yes <input type="checkbox"/> No How many hours have you logged? _____				
	Scuba Diving? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, are you PADI certified? <input type="checkbox"/> Yes <input type="checkbox"/> No How deep do you dive? _____ Do you dive with a dive master or instructor? <input type="checkbox"/> Yes <input type="checkbox"/> No How often do you dive? _____ What type of equipment do you use? _____ What are the locations of the dives? _____ Are you a member of an organized club? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DRIVING HISTORY	In the last 5 years, have you been charged or convicted of driving under the influence of alcohol or drugs or had any driving violations? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	Number of speeding or moving violations in the last 5 years: Did it result in an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Was anyone injured? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Please give as much additional information as possible regarding this case in a separate letter or on the back of this form.

DO NOT RETURN UNLESS ALL QUESTIONS HAVE BEEN ANSWERED

Required completion by Writing Agent:

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email Address: _____



BAKER ASSOCIATES

**AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION
TO BAKER ASSOCIATES**

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

_____/_____/_____
Name of proposed insured/patient (please print) Date of birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Provider") to disclose my entire medical record and any other protected health information concerning me to Baker Associates. 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____/_____/_____
Signature of Proposed Insured/Patient or Personal Representative Date

Description of Personal Representative's Authority or Relationship to Proposed Insured/Patient

AIG	Banner	Liberty Life	North American	Sun Life
Allianz	GE Assurance	Lincoln Benefit	Pacific Life	Transamerica
American General	Genworth	Lincoln Financial	Phoenix Life Ins. Co.	Union Central
American National	Indianapolis Life	Lincoln National	Principal Financial	United of Omaha
Amerus	ING	MetLife Investors	Prudential	West Coast Life
AXA	John Hancock	MetLife Brokerage	ReliaStar	
Baker Associates	LexNet, L.P.	Millennium Brkg Grp	Security Connecticut	



BAKER ASSOCIATES

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer-reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to Baker Associates.

The types of information will include records or facts related to employments, other insurance coverage, past and present physical and mental slate of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit, or other personal traits.

The insurance companies named below and their reinsurers to determine eligibility for insurance, claims and/or by the insurance agent to aid in updating and improving my insurance program.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organization performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing; I understand that I may request to receive a copy of this Authorization.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices.

Instruction to agent: the notification on the next page must be given to the proposed insured before or at the time of signature.

AIG	Banner	Lincoln Benefit	Pacific Life	Transamerica
Allianz	GE Assurance	Lincoln Financial	Phoenix Life Ins. Co.	Union Central
American General	Genworth	Lincoln National	Principal Financial	United of Omaha
American National	Indianapolis Life	MetLife Investors	Prudential	West Coast Life
Amerus	John Hancock	MetLife Brokerage	ReliaStar - ING	
AXA	LexNet, L.P.	Millennium Brkg Grp	Security Connecticut	
Baker Associates	Liberty Life	North American	Sun Life	

Signed at _____ this _____ day of _____ 20 _____
Signature of Proposed Insured



BAKER ASSOCIATES

NOTICE TO PROPOSED INSURED *(Leave with Insured)*

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interview with your family, friends, neighbors, business associates, financial sources or others with whom you, are acquainted This report includes information as to your character, general reputation, personal characteristics and mode of living. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumers report was requested and, if so, you will be advised of the name and address of the consumer-reporting agency to which the request was made The consumer-reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer-reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone: (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of property underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information, from others, such as medical professionals who have treated you.

In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right m be told about and to see a copy, if you wish, of items of personal information about you which appear in the insurance companies' files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES AND YOUR AGENTS INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUESTS TO: Baker Associates.

AIG	Banner	Liberty Life	North American	Sun Life
Allianz	GE Assurance	Lincoln Benefit	Pacific Life	Transamerica
American General	General American	Lincoln Financial	Phoenix Life Ins. Co.	Union Central
American National	Genworth	Lincoln National	Principal Financial	United of Omaha
Amerus	Indianapolis Life	MetLife Investors	Prudential	West Coast Life
AXA	John Hancock	MetLife Brokerage	ReliaStar - ING	
Baker Associates	LexNet, L.P.	Millennium Brkg Grp	Security Connecticut	

A Full Service Agency specializing in Estate Planning, Supplemental Retirement Plans, and Business Concepts

8444 N. 90th Street, Suite 110 • Scottsdale, AZ 85258
Phone: 480.538.1004 Fax: 480.438.1005



HIPAA RELEASE TO OBTAIN AND DISCLOSE INFORMATION

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

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person that has provided payment, treatment, or other services to me or on my behalf within the past 20 years to disclose to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to The Producers Group, affiliated of Freundt & Associates Insurance Services Inc.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health to include information on the treatment of Human Immunodeficiency Virus (HIV), infection and sexually transmitted diseases, drug and/or alcohol use, diagnosis or treatment of mental illness, character habits, avocations, finances, reputation, credit, or other personal traits.

I understand that the information authorized for release may also include life insurance policy information, including but not limited to applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my life insurance company to furnish The Producers Group with any information herein described above.

The information will be used by the insurance companies named below and their reinsurers to determine eligibility and risk rating for insurance, claims and/or by the insurance agent to aide in updating and improving my insurance program.

Any protected health information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing and a copy of this Authorization is as good as the original. I understand that I may request to receive a copy of this Authorization.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices. I understand that if I refuse to sign this Authorization to release my complete medical records, the insurance companies named below may not be able to process my application.

INSTRUCTION TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

- 21st Services
American General
Coventry First
Hartford Life Insurance
John Hancock
Lincoln Benefit Life
Metlife Investors
Pacific Life
Sun Life of Canada
US Financial Life
AVS
AXA Financial
Empire General
Indianapolis Life
Lafayette Life
Lincoln Life
New York Life
Presidential Life
Transamerica
US Life
AVIVA
Banner Life
General American
ING
Life Settlement Alliance
Manulife
North American
Principal Financial
Travelers
West Coast Life
Advanced Settlements
Columbus Life
Genworth Financial
Jefferson Pilot
LSIS
Mass Mutual
Old Mutual Financial Network
Prudential
United of Omaha
William Penn

Signed at _____ this _____ day of _____ 20_____

X _____
(Signature of Proposed Insured)