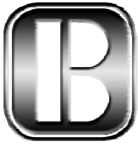


Baker Associates

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 – ❒ Yes Cigar, Cigarettes, Pipe or Chew ❒ No		Last Date Used
Amount	Plan: ❒ Term ________ Years		❒ Permanent		❒ Survivorship

INSURANCE IN-FORCE

Is this for Replacement? ❒ Yes ❒ No	
Have you ever been: ❒ Declined? ❒ 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? ❒ Yes ❒ 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.		4.	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?

❒ Yes
❒ No

If yes, list country, date, length of stay and purpose.

Date	Country	Length of Stay	Purpose
			❒ Business ❒ Personal

AVOCATIONS (SPORTS, AVIATION, SCUBA DIVING)

Do you participate in extreme sports or other hazardous activities? ❒ Yes ❒ 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? ❒ Yes ❒ No

If yes, are you certified? ❒ Yes ❒ No

How many hours have you logged? _____________

Scuba Diving? ❒ Yes ❒ No

If yes, are you PADI certified? ❒ Yes ❒ No

How deep do you dive? _____________

Do you dive with a dive master or instructor? ❒ Yes ❒ 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? ❒ Yes ❒ 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?

❒ Yes ❒ No

Number of speeding or moving violations in the last 5 years:

Did it result in an accident? ❒ Yes ❒ No Was anyone injured? ❒ Yes ❒ 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: I) 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 OFTHE LISTED INSURANCE COMPANIES AND YOUR AGENTS INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SENDYOUR 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	

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.

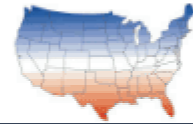
INSTRUCTION TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

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

Signed at ______________________________this________day of __________________20______

X____

(Signature of Proposed Insured)



Authorization to Obtain/Waiver and Acknowledgment Form

HIPAA AUTHORIZATION:

I, AUTHORIZE any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Brokers Alliance, Inc. and its agents, employees, and representatives. 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 record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this authorization so that Brokers Alliance, Inc. may 1) underwrite my application for coverage by making eligibility, risks rating, policy insurance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied fro with the Insurance Companies named below.

AIG/ American General
American National Life
Allianz Life
Assurity Life
AXA Equitable
Banner Life
Companion Life of New York
Genworth
ING / Reliastar Life
John Hancock
Lincoln Financial Group
Lincoln Benefit Life
Met Life Investors
North American Company for Life and Health
Prudential Life
Protective Life
SBLI
Transamerica
United of Omaha
West Coast Life

Other Insurance Company: ____

This authorization shall remain in force for 24 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 Brokers Alliance, Inc., 16921 E. Palisades Blvd., Suite 103, Fountain Hills, AZ 85268, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization 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 federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT

This Waiver and Acknowledgment (the “Waiver”) has been signed on the date set forth below by the undersigned (the “Applicant”) in favor of Brokers Alliance, Inc., its successors, assigns, shareholders, directors and employees (collectively “Brokers Alliance”).

Applicant acknowledges, understands and agrees as follows:

- That Applicant has filed an application with Brokers Alliance intending to secure life insurance from one or more insurance underwriters.
- That in the course of applying for life insurance coverage, Brokers Alliance, has asked for and received information concerning Applicant’s medical condition and history, as well as other information that is of a personal and confidential nature.
- That Brokers Alliance will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- That Brokers Alliance maintains, or will maintain, an electronic data interchange (the “Interchange”) through which certain authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as “Underwriters”) mat gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- That Brokers Alliance will use the Interchange to store some or all of the confidential and personal information Applicant has provided to Brokers Alliance, and, therefore, that Underwriters will be able to gain access to that information through the exchange.
- That the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- That, even though Brokers Alliance has in place security measures Brokers Alliance believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though Brokers Alliance will continue to upgrade those security measures from time to time as circumstances warrant, Brokers Alliance can make no guarantee as to Brokers Alliance’s ability to protect the Interchange and the information it contains from unauthorized access by “hackers” or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
- That Brokers Alliance cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
- That Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in Brokers Alliance’s possession and/or stored on the Interchange.
- That Applicant will indemnify Brokers Alliance for all costs and expenses incurred by Brokers Alliance or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgement, understand, and agreement with respect to the foregoing by signing this document below.

I **ACKNOWLEDGE** that I have received a copy of this document.

I **AGREE** this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: _______/______/_______

City: ___________________________________ State: _____________________________

X ____
Signature of Proposed Insured/Parent or Guardian

X ___________________________________
Signature of Witness

____
Printed name of Proposed Insured/Parent or Guardian

Brokers Alliance, Inc
Privacy Policy

At Brokers Alliance, Inc., protecting your privacy is very important us. We are strongly committed to safeguarding the information you provide us and to use it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

Collection of Information

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms, and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties, including but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

Disclosure of Information

We will not share nonpublic personal information concerning our potential, current, or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your account;
- Your agent or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, like banks, and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies.

When we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information.

Protection of Information

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Brokers Alliance, Inc., your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic, and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.