Baker Associates

Preliminary Inquiry (Confidential)

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

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 ☐ No Cigar, Cigarettes, Pipe or Chew		Last Date Used
Amount	Plan: ☐ Term Years _____		☐ Permanent		☐ Survivorship

INSURANCE IN-FORCE

Is this for Replacement? ☐ Yes ☐ No	Company Name	Amount	Year Issued Plan

Have you ever been: ☐ Declined? ☐ Rated? Give Details	Company Name	Year	Reason	Rating

Is Trial of Formal application pending or being contemplated with any Insurance company? ☐ Yes ☐ No

If yes, what Company? What premium can be placed?

PRELIMINARY HEALTH 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?			

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

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

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

DO NOT REURN UNLESS ALL QUESTIONS HAVE BEEN ANSWERED

Required completion by Writing Agent:

Name: _____ Address: _____ _____

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

If being shopped, where? _____

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	Chase	John Hancock	North American	Travelers
Allianz	First Penn	Lincoln Benefit	Phoenix Home Life	United of Omaha
American General	GE Assurance	Lincoln Financial	Principal Financial	US Financial
American National	General American	Lincoln National	Prudential	West Coast Life
Amerus	Genworth	MetLife Investors	ReliaStar	
AXA	Indianapolis Life	MetLife Brokerage	Security Connecticut	
Baker Associates	ING	Millennium Brkg Grp	Sun Life	
Banner	Jefferson Pilot	MONY	Transamerica	

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	Chase	John Hancock	North American	Travelers
Allianz	First Penn	Lincoln Benefit	Phoenix Home Life	United of Omaha
American General	First Colony	Lincoln Financial	Principal Financial	US Financial
American National	GE Assurance	Lincoln National	Prudential	West Coast Life
Amerus	General American	MetLife Investors	ReliaStar - ING	
AXA	Genworth	MetLife Brokerage	Security Connecticut	
Baker Associates	Indianapolis Life	Millennium Brkg Grp	Sun Life	
Banner	Jefferson Pilot	MONY	Transamerica	

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	Chase	John Hancock	North American	Travelers
Allianz	First Penn	Lincoln Benefit	Phoenix Home Life	United of Omaha
American General	First Colony	Lincoln Financial	Principal Financial	US Financial
American National	GE Assurance	Lincoln National	Prudential	West Coast Life
Amerus	General American	MetLife Investors	ReliaStar - ING	
AXA	Genworth	MetLife Brokerage	Security Connecticut	
Baker Associates	Indianapolis Life	Millennium Brkg Grp	Sun Life	
Banner	Jefferson Pilot	MONY	Transamerica	

7502 E. Pinnacle Peak Road, Suite B116 • Scottsdale, AZ 85255
Phone: 480.538.1004 Fax: 480.438.1005

THE PRODUCERS GROUP
people business products

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)