



**CONFIDENTIAL TRIAL
INQUIRY**

SIGNATURE REQUIRED

RETURN TO:
90 MADISON ST, SUITE 503
DENVER, CO 80206
(303) 321-0565 (800) 835-5942

PERSONAL INFORMATION			
Applicant's Name	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth	Social Security #
Address <i>(City, State, Zip Code)</i>			Phone #
Height	Tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, what type?	
Weight		When last used?	Frequency of Use?

INSURANCE INFORMATION			
Type of Insurance Applying for:	Amount Desired	State of Issue	Total Amount of Insurance In Force
Term <input type="checkbox"/> Universal Life <input type="checkbox"/>	Replacement? Y <input type="checkbox"/> N <input type="checkbox"/>	Previous Coverage Details (Company; Face Amt; Premium)	
Variable Life <input type="checkbox"/> Whole Life <input type="checkbox"/>			
Individual <input type="checkbox"/> Survivorship <input type="checkbox"/>			
Is applicant negotiating or within the last 6 months negotiated for Life Insurance elsewhere? (Please give details - Company and Outcome)			

MEDICAL INFORMATION			
Health Impairment(s)			
Medications			
Physicians/Hospitals visited in the last 5 years			
	Physician/Hospital Name	Address & Phone #	Date
PCP			
Other			
Other			
Other			
Family History - any immediate family member died before age 60? If yes, please provide cause and age at death.			

BROKER INFORMATION		
Broker's Name	Company Name	
Address	Phone	Email Address

CARDIAC		
Condition – Describe in detail		
Date of Condition	Date of last Echocardiogram	Current Physician treating Cardiac
Did you have Angioplasty?	Y <input type="checkbox"/> N <input type="checkbox"/>	If Yes, please indicate the date of last Angioplasty:
Did you have Bypass Surgery?	Y <input type="checkbox"/> N <input type="checkbox"/>	If Yes, Number of Vessels by-passed:
Did you have a Heart Attack?	Y <input type="checkbox"/> N <input type="checkbox"/>	If Yes, please indicate date of Heart Attack:
Additional Tests or Procedures Completed:	Please give dates and results	

DIABETIC		
Date of Diabetic Diagnosis	Age at time of Diagnosis	Current Physician treating Diabetes
Form of Treatment	Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> Diet Only <input type="checkbox"/>	If Insulin – How many units per day? If Oral – type of medication and daily dosage?
Date of last FBS (fasting blood sugar) test	Last Glucose Reading	Last A1-C Reading
Date of last A1-C test	Is Home monitoring being done? Y <input type="checkbox"/> N <input type="checkbox"/>	
History of Diabetic Complications (if any)		
High Blood Pressure? Y <input type="checkbox"/> N <input type="checkbox"/>	Diabetic Eye Disease? Y <input type="checkbox"/> N <input type="checkbox"/>	Heart Disease? Y <input type="checkbox"/> N <input type="checkbox"/>
Kidney Disease? Y <input type="checkbox"/> N <input type="checkbox"/>	Neurological Disease? Y <input type="checkbox"/> N <input type="checkbox"/>	Other? Y <input type="checkbox"/> N <input type="checkbox"/>
Please explain other or give details to "Yes" answers		

CANCER		
Date of Diagnosis	Tumor/Cancer Location	Current Physician treating Cancer
What Stage?	I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>	What Group? A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/>
Pathology diagnosis		
Was there any lymph node involvement? Y <input type="checkbox"/> N <input type="checkbox"/>	If Yes, how many lymph nodes?	
Was there any metastasis (spread) to any other organ tissue? Y <input type="checkbox"/> N <input type="checkbox"/>	If Yes, please provide details	
What kind of Treatment?	Radiation <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Oral <input type="checkbox"/> Medication Surgery <input type="checkbox"/>	Date of Last Treatment



Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **Colorado Brokerage Group, LLC** and its affiliated agencies, including but not limited to RSA Medical, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years (“my Providers”) to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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, my prescription records and history of medications prescribed but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to **Colorado Brokerage Group, LLC** and its affiliated agencies, including but not limited to RSA Medical. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as **Colorado Brokerage Group, LLC** and its staff, employees and affiliated companies, including but not limited to RSA Medical.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, **Colorado Brokerage Group, LLC** may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured’s Signature | Date

Proposed Insured’s Name | Signed At (City, State, Zip)

Agent/Witness Signature | Date

American General Life Insurance Company, American National Insurance Companies, AXA Equitable Life Insurance Company, Aviva, Banner Life Insurance Company, Companion Life Insurance Company, Coventry First, Genworth Financial Family of Companies, Hartford Life Insurance Company, ING USA Annuity and Life Insurance Company, John Hancock, Lincoln Benefit Life, Lincoln Financial Group, MassMutual Financial Group, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Nationwide Life, Pacific Life; Protective Life Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Security Life of Denver Insurance Company, Sun Life Insurance & Annuity Company, Transamerica Life Insurance Company, U.S. Financial Life Insurance, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, West Coast Life Insurance Company, William Penn Life Insurance Company of New York

NOTICE TO PROPOSED INSURED

In connection with your formal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources or other 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 consumer 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 on informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance, 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 a disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek 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 properly 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 that 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 to be told about, and to see a copy, if you wish, of the 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.

You have the right to revoke this authorization by sending written request to 90 Madison Street, Suite 503; Denver, CO 80206; Attn: Authorization. Alternatively you may revoke the authorization by sending a written request directly to My Providers.

The above is a general description of the listed insurance companies and your agent's information practices. If you would like to receive a more detailed explanation of these practices, please send your request to:

Colorado Brokerage Group, LLC, 90 Madison Street Suite 503, Denver, CO 80206.