Print Form | Submit by Email

# Affilated Marketing Group Trial Application

| Primary Applicant's Name | Sex | DOB | SSN |
|---|---|---|---|
| Address | | | Phone |
| Height | Tobacco User? | If yes, what type? | |
| Weight | | When last used? | |

| Type of Insurance Applying For | Amount | State of Issue |
|---|---|---|
| Replacement? | Previous Coverage Details | Total Amount of Insurance In Force |

Family History - Show age and present health, or if deceased, show age at death and cause of death.

| | Age | Present Health | Cause of Death | Age at Death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother/ Sister | | | | |
| Brother/ Sister | | | | |

| Health Impairment(s) | | | |
|---|---|---|---|
| Medications and Dosage | | | |
| | | | |

Physicians or Hospitals visited in last five years:

| | Name, Address, Phone Number | Date | Reason for Visit? Illness? |
|---|---|---|---|
| Primary Personal Physician | | | |
| Additional Physicians and/or Hospitals | | | |
| | | | |
| | | | |
| | | | |

| Broker's Name | | |
|---|---|---|
| Company | Broker Dealer | |
| Address | | |
| Phone | Fax | Email |
| Are We In Competition? | If yes, with whom? | |

***Continued on next page***

*Please complete applicable questionnaire(s):* Applicant Name: _____

| **Chest Pain Questionnaire** | |
|---|---|
| Date of first episode of chest pain | Were you hospitalized? Choose |
| Date of most recent episode of chest pain | |
| What was the final diagnosis made concerning your heart condition? | |

| **By-Pass Surgery Questionnaire** | |
|---|---|
| Date of by-pass surgery | Number of vessels by-passed |
| Heart attack before surgery? | Any chest pain since the by-pass operation? |
| Date of last exercise (stress) ECG | Results |

| **Angioplasty Questionnaire** | |
|---|---|
| Date of angioplasty | Date of previous angioplasty |
| Heart attack before angioplasty? | Chest pain since angioplasty procedure? |
| Date of last exercise (stress) ECG | Results |

| **Diabetic Questionnaire** | | |
|---|---|---|
| Date of diagnosis of diabetes | Age at time of diagnosis | |
| Current Physician treating diabetes | Date of last visit | |
| Form of treatment | If Insulin, how many units per day?<br>If Oral, type of medication and dosage per day? | |
| Date of last FBS (fasting blood sugar) test | Glucose reading | |
| Date of last A1-C (glycohemoglobin) test | A1-C reading | |
| Is home monitoring being done? | | |
| Diabetic Complications **-** Any history of: | | |
| High blood pressure? | Diabetic eye disease? | Heart disease? |
| Kidney disease? | Neurological disease? | |

| **Cancer Questionnaire** | | |
|---|---|---|
| Date of diagnosis | Tumor location | |
| Pathology diagnosis | | |
| What Stage? | What Group? | |
| Was there any lymph node involvement? | If yes, how many? | |
| Was there any metastasis (spread) to any other organ tissue? | If yes, please identify | |
| What kind of treatment? | Date of last treatment | |

Signature of Proposed Insured _____ Date _____

# Affiliated Marketing Group

## HIPAA RELEASE TO OBTAIN AND DISCLOSE INFORMATION

I hereby authorize Affiliated Marketing Group and _____("my Representative") and it's staff, affiliated companies and/or entities, insurance companies and their re-insurers, to possess, obtain and/ or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long term care or other insurance products.

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 payment, 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 include 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 my signature below, I terminate any agreements I have made with my Providers to restrict my medical records and associated HIPAA protected health information and I instruct my providers to release and disclose my entire medical record without restriction. 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 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 Affiliated Marketing Group, affiliated insurance companies and their re-insurers.

The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices.

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 my 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, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

| | | |
|---|---|---|
| *AIG/ American General* | *American National Insurance Co.* | *Banner Life* |
| *Empire General* | *Genworth Companies* | *ING Companies* |
| *John Hancock* | *Lincoln Benefit Life* | *Met Life Investors* |
| *Prudential Financial* | *Mutual of Omaha* | *US Financial Life Ins. Co.* |

Proposed Insured's Name _____

Proposed Insured's Signature _____

Agent / Witness _____

Signed and Dated on _____ At _____(City and State)

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| | | |
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| *Empire General* | *Genworth Companies* | *ING Companies* |
| *John Hancock* | *Lincoln Benefit Life* | *Met Life Investors* |
| *Prudential Financial* | *Mutual of Omaha* | *US Financial Life Ins. Co*. |

***Client Copy***