Informal Medical Questionnaire

Personal History—Proposed Insured

Name_____ ☐ Male ☐ Female Social Security Number_____

US Citizen? ☐ Yes ☐ No Date of Birth_____ Birth State_____ Phone Number_____

Age_____ Height_____ Weight_____ Driver's License Number_____ Driver's License State_____

Address_____ City_____ State_____ Zip_____

Occupation_____ Duties_____

What is your annual earned income?_____ What is your annual unearned income?_____

What is your personal net worth?_____ Email _____

Lifestyle

Did you lose or gain more than 10 pounds in the past year? ☐ Yes ☐ No If yes, explain reason for weight change:

_____

Do you engage in regular exercise? ☐ Yes ☐ No If yes, list the type(s) of exercise:_____

How many times a week?_____ How long per occasion?_____

Do you currently use tobacco products? ☐ Yes ☐ No If yes, please select type and indicate amount:

☐ Cigarettes ☐ Chewing Tobacco ☐ Cigars ☐ Pipe ☐ E-Cigarette ☐ Other:_____

Amount:_____per ☐ day ☐ week

Have you ever used tobacco products? ☐ Yes ☐ No If yes, complete the date last used and indicate the type of tobacco used: Date:_____ Type:_____

Do you currently use marijuana? ☐ Yes ☐ No If yes, please indicate the frequency:
Number of times weekly:_____ monthly:_____

Any history or treatment of drug/alcohol use? ☐ Yes ☐ No If yes, explain or complete alcohol/drug questionnaire:

_____

Any history of moving violations? ☐ Yes ☐ No If yes, explain or complete reckless driving questionnaire:

_____

Are you a pilot and/or do you participate in any activities such as scuba diving, rock climbing, motor cross, etc.?

☐ Yes ☐ No If yes, provide details:_____

Do you intend to reside or travel outside of the United States within the next two years? ☐ Yes ☐ No

If yes, please provide city, country, dates/duration and purpose of all travel:_____

Requested Coverage

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship ☐ Variable

Face amount desired $_____ Premium amount desired $_____

What will be the purpose of the insurance?_____

Have you ever been declined or rated when applying for life insurance? ☐ Yes ☐ No

If yes, when and why?_____

This is not an application for life insurance.

TRUSTMARK FINANCIAL GROUP

Informal Medical Questionnaire

Existing Insurance *Do you currently have active insurance coverage? Will this coverage be replaced?*

Company	Type	Amount	Replacing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medical History *Please answer the following questions and provide detail to any "yes" answers.* Who is your personal physician? (Doctor's name, address and phone number)

Name_____ Address_____

City_____ State_____ Zip_____ Phone Number_____

Date Seen:_____ Reason/Diagnosis:_____

What other medical practitioners or health care providers have you consulted during the past five years? (Do not include insurance examinations.)

Name_____ Address_____

City_____ State_____ Zip_____ Phone Number_____

Date Seen:_____ Reason/Diagnosis:_____

Name_____ Address_____

City_____ State_____ Zip_____ Phone Number_____

Date Seen:_____ Reason/Diagnosis:_____

Name_____ Address_____

City_____ State_____ Zip_____ Phone Number_____

Date Seen:_____ Reason/Diagnosis:_____

Name_____ Address_____

City_____ State_____ Zip_____ Phone Number_____

Date Seen:_____ Reason/Diagnosis:_____

In what clinics or hospitals have you ever been treated?

_____ Date Seen:_____ Reason/Diagnosis:_____

_____ Date Seen:_____ Reason/Diagnosis:_____

_____ Date Seen:_____ Reason/Diagnosis:_____

_____ Date Seen:_____ Reason/Diagnosis:_____

Please list all current medications, purposes and doses (both prescribed and non-prescribed.)

_____ Purpose:_____ Dosage:_____

_____ Purpose:_____ Dosage:_____

_____ Purpose:_____ Dosage:_____

_____ Purpose:_____ Dosage:_____

_____ Purpose:_____ Dosage:_____

Do you have any upcoming procedure or office visit planned with any physician? ☐ Yes ☐ No

If yes, please give details:_____

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Informal Medical Questionnaire

Medical History Continued

Please answer the following questions and provide detail to any "yes" answers.

Any cancer, cardiovascular or diabetes history/deaths prior to age 60 among your parents or siblings? ☐ Yes ☐ No

If living, please provide age:	**If deceased, please provide age at death and cause of death:**		**(Cancer of Any Type)**
Living:	Deceased, age at death:		
Mother:_____	Mother:_____	Cause of death:_____	☐ Yes ☐ No
Father:_____	Father: _____	Cause of death:_____	☐ Yes ☐ No
Sibling:_____	Sibling:_____	Cause of death:_____	☐ Yes ☐ No
Sibling:_____	Sibling:_____	Cause of death:_____	☐ Yes ☐ No

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:

Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heartbeat, or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No

Diabetes or disease of any glands? ☐ Yes ☐ No

Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? ☐ Yes ☐ No

Arthritis, gout, or any bone, joint, muscle or skin disorder? ☐ Yes ☐ No

Asthma, bronchitis, pneumonia, emphysema or any lung disorder? ☐ Yes ☐ No

Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines? ☐ Yes ☐ No

Prostate or testicular disease, disease of the uterus, ovaries or breast? ☐ Yes ☐ No

Anemia, leukemia, clotting disorders, or platelet disorders? ☐ Yes ☐ No

Disorder of the urinary tract or kidneys – sugar, albumin or blood in the urine? ☐ Yes ☐ No

Cancer or tumors? ☐ Yes ☐ No

An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance?) ☐ Yes ☐ No

Any other health impairment or medically treated condition not previously mentioned? ☐ Yes ☐ No

Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS in the space below. Attach additional pages if necessary. Please be specific with this information for it will expedite the process.

_____

_____

_____

_____

Agent Information

Name_____ Firm_____

Social Security Number_____ Phone Number_____

This is not an application for life insurance.

TRUSTMARK FINANCIAL GROUP

Authorization to Obtain and Disclose Confidential Information

This form is HIPAA Compliant

Proposed Insured's Name: _____

Date of Birth: _____ SSN: _____

Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Trustmark Financial Group LLC, brokers, contractors, employees, representatives and agents working for or through Trustmark Financial Group LLC for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurers & Agencies

Accordia Life and Annuity Company
Allianz Life Insurance Company
American General Life Insurance Co.
American National Insurance Co.
American National Insurance Co. of New York Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of New York
Ashar Group, LLC
AXA Equitable Life Insurance Co.
Banner Life
Brighthouse Financial
Columbus Life Insurance Company
Coventry First, LLC
Genworth Insurance Company of New York
Genworth Life Insurance Co.
Highland Capital Brokerage, Inc.
John Hancock Life Insurance Co. (U.S.A.)
John Hancock Life Insurance Co. of New York
Life Insurance Company of the Southwest
Life Insurance Settlements, Inc.
Lincoln National Life Insurance Co.
Lincoln Life & Annuity Co. of New York
Lloyds of London
Massachusetts Mutual Life Insurance Company
Minnesota Life Insurance Company
Mutual of Omaha Insurance Company
National Life Group
Nationwide Life & Annuity Co.
New York Life Insurance & Annuity Co.
New York Life Insurance Co.
North American Company for Life and Health Insurance
OneAmerica
Pacific Life Insurance Co.
Pacific Life & Annuity Co.
Penn Mutal Life Insurance Company
Petersen International
Principal Life Insurance Company
Principal National Life Insurance Co.
Protective Life Insurance Co.
Protective Life & Annuity Insurance Co.
Pruco Life Insurance Co.
Pruco Life Insurance Co. of New Jersey
Prudential Insurance Co. of America
RGA/Reinsurance Group of America
Securian Life Insurance Company
Symetra Life Insurance Co.
Transamerica Life Insurance Co.
Transamerica Life Insurance & Annuity Co.
Transamerica Financial Life Insurance Co.
TruChoice Financial, LLC
United of Omaha
United States Life Insurance Co.
USG Annuity & Life
Voya Financial
Zurich American Life Insurance Co.
Zurich American Life Insurance Co. of New York

Additional Insurers & Agencies

_____

_____

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) AIDS/HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment,(7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

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I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

With this signed Authorization to Obtain and Disclose Confidential Information, I specifically authorize any medical practitioner, any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer to release and disclose the protected health information (PHI) described above to the following authorized recipient of the PHI, for the purpose described above:

☑ TruChoice Financial Group at 400 Highway 169 South, Suite 200 Minneapolis, MN 55426

OR

☐ Other: _____

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed afore may use the secured internet-based system called "PaperClip, Inc." to store/access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below. This authorization shall also extend to records of future treatment after the date of signing this authorization as long as such treatment occurs while this authorization is still in effect.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____, (year) _____

Signature of Proposed Insured or Individual's Legally Authorized Representative:

_____

Printed Name of Authorized Representative (if applicable): _____ Relationship to Individual: _____

Signature of Witness: _____

Signature of Policy Owner(s): _____

(not required)

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child: _____ Relationship of Representative to Minor: _____

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NOTICE TO PROPOSED INSURED

Instructions to Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning 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 others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

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

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their 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 NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES. EACH INSURER NAMED HEREIN REQUIRES THE COMPLETION OF A FULL APPLICATION FOR ITS RESPECTIVE PRODUCT LINES.