Life Insurance: Informal Application

SIMPLICITY GROUP

This is not an application for life insurance. The informal application is used exclusively to gather specific details on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.

Today's Date: _____

Agent Information (Required)

Name: _____ Tel. #: _____

Social Security #: _____ E-mail: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured Information (Required)

Name: _____ Date of birth: _____ ☐ Male ☐ Female

Address: _____

Primary tel. #: _____ Social Security #: _____

Monthly income: _____ Total net worth: _____

Occupation: _____

Driver's license #: _____ State _____ Expiration date: _____

Are you a US Citizen ☐ Yes ☐ No If no, Visa type: _____

Have you or do you intend to travel outside of the US in the past/next 12 months? ☐ Yes ☐ No

If yes, please provide details of travel: _____

_____

Plan Information

Plan of insurance you are inquiring about:

☐ Whole Life ☐ Universal Life ☐ Term Life: (Duration_____) ☐ Survivorship ☐ Variable

Face amount: _____ Premium budget: _____ Premium mode: _____

Sate of sale: _____ Purpose of insurance: _____

Any life, disability, or annuity policies currently in-force?: ☐ Yes ☐ No

Carrier	Face Amount	Year Issued	Premium	Replacement	Owner/Purpose

Has this case been submitted to other companies in the past 12 months? ☐ Yes ☐ No (If yes, please list below):

Company: _____ Date submitted: _____

Action Taken: _____

Company: _____ Date submitted: _____

Action Taken: _____

Company: _____ Date submitted: _____

Action Taken: _____

Tobacco/Nicotine Use

Have you ever used any kind of tobacco product? ☐ Yes ☐ No

If yes, forms used: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Dip/chew ☐ Nicotine Gum ☐ E-Cigarette/vape

☐ Other _____

Frequency: _____ Date of last usage: _____

Drug/Alcohol Use

Do you currently drink alcohol? ☐ Yes ☐ No Date of last consumption: _____

Type of Alcohol: _____ Frequency: _____

Type of Alcohol: _____ Frequency: _____

Have you ever consulted a doctor or received treatment for alcohol abuse? ☐ Yes ☐ No

Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No (If Yes, date: _____)

Have you ever used illegal drugs, consulted a doctor, or received treatment for drug abuse? ☐ Yes ☐ No

Types of Drugs Used: _____

Date(s) Last Used: _____ Are you currently involved in a 12-Step Program? ☐ Yes ☐ No

Marijuana Use

Have you ever used any kind of marijuana/CBD product? ☐ Yes ☐ No

If yes, reason for use: ☐ Recreational ☐ Medicinal

Delivery method: ☐ Ingested ☐ Vaporized ☐ Smoked ☐ Other _____

Frequency: _____ Date of last usage: _____

If medicinal, reason prescribed _____ Frequency: _____

Hazardous Activities - Only complete if applicable

Are you a pilot? ☐ Yes ☐ No (If Yes, please provide details below):

How many total hours have you flown as Pilot in Command? _____ How many hours do you fly per year? _____

Are you IFR (Instrument Flight Rated)? ☐ Yes ☐ No

Do you participate in any of the following activities? (Check all that apply)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving ☐ Mountain Climbing

☐ Hang Gliding ☐ Auto Racing ☐ Motorcycle Racing ☐ Other (details): _____

_____

_____

If you checked any of the above activities please contact our New Business department for additional forms that may be required to complete the underwriting assessment.

Medical Information

Height: _____ Weight: _____

Have you had any significant weight change (10 lbs. or more) over the last 12 months? ☐ Yes ☐ No

If yes, please explain reason for weight change: _____

Blood Pressure and Cholesterol:

Latest BP reading: _____ /_____Latest total cholesterol: _____ mg; Latest cholesterol/HDL ratio: _____

Have you ever had, been told you had, or been treated for any of the conditions listed? (check all that apply)

Doctor Information

☐ Dementia/cognitive impairment
☐ Asthma
☐ Cancer
☐ Cirrhosis
☐ COPD
☐ Coronary artery disease
☐ Cerebrovascular disease
☐ Colitis or Crohn's disease
☐ Depression/anxiety
☐ Diabetes
☐ Drug abuse
☐ Heart murmur/valve disease
☐ Hepatitis
☐ Internal organ transplant
☐ Irregular heartbeat/palpitations
☐ Kidney disease
☐ Lupus
☐ Multiple sclerosis
☐ Peripheral vascular disease
☐ Rheumatoid arthritis
☐ Seizure
☐ Sleep apnea
☐ Stroke or TIA
☐ Other_____

Primary care physician's name: _____

Address: _____

Tel. #:_____

Date last seen: _____ Reason for visit: _____

Please list all doctors seen in the last 5 years along with reason for visit:

Name/specialty: _____City, State: _____

Tel. #: _____Date seen/reason: _____

Name/specialty: _____City, State: _____

Tel. #: _____Date seen/reason: _____

Name/specialty: _____ City, State: _____

Tel. #: _____ Date seen/reason: _____

List all medication you have been prescribed in the last 12 months and include dosage:

_____

_____

Family History

Has any immediate family member (parent/sibling) been diagnosed or died from heart disease, cancer, stroke or diabetes?

☐ Yes ☐ No If yes, please provide details:

Relation: _____ Diagnosis: _____

Age at onset: _____ Age at death (if applicable): _____

Relation: _____ Diagnosis: _____

Age at onset: _____ Age at death (if applicable): _____

Relation: _____ Diagnosis: _____

Age at onset: _____ Age at death (if applicable): _____

Coronary Artery Disease - Only complete if applicable

Date of diagnosis or first chest pain: _____ Number of Diseased Vessels: _____

Dates/details or treatments/surgery (example: Angioplasty, Bypass): _____

_____

_____

Date of last stress EKG: _____ Results: _____

Physician that completed: _____

City/State of physician: _____ Tel. #: _____

Any pain since treatment/surgery? ☐ Yes ☐ No

Cancer - Only complete if applicable

Exact name and location of cancer: _____

Stage and grade: _____

Physician contact information to obtain pathology report: _____

Dates/details or treatment/surgery: _____

_____

Diabetes - Only complete if applicable

Date of Diagnosis: _____

Treatment: (Check all that apply)

☐ Diet only ☐ Oral medication ☐ Insulin ☐ Other (specify) _____

Do you regularly test your blood for glucose? ☐ Yes ☐ No Frequency: _____Avg Result: _____

Latest result of glycohemoglobin (A1C) test: _____ mg%

Have you ever had any of the following? (Check all that apply)

☐ Eye Trouble ☐ Heart Trouble ☐ High Blood Pressure ☐ Kidney Trouble

☐ Neuropathy/Neuralgia ☐ Insulin Reaction (Explain below) ☐ Protein/Microalbumin

_____

_____

Please provide any additional information you feel necessary to enhance our underwriting process.

_____

_____

_____

_____

_____

_____

This form is HIPAA compliant.

Authorization for Release of Information

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) 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.

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.

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. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance 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, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure 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.

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 _____20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

Date of Birth_____ Social Security Number _____

Authorized Recipients
Insurance Companies and Agencies

Accordia Life	Gleaner Life Insurance Society	Penn Mutual
AGLA	Global Atlantic/Forethought Life	Principal
Allianz	Integrity Life	Prosperity Life
American Equity	Jetstream	Protective Life
American National	John Hancock	Prudential
Americo	Knighthead Annuity	Reliance Standard
Ameritas	International	Royal Neighbors
Annexus	Lafayette Life	Sagicor
ASPIDA	Legacy Marketing	SBLI
Assurity	Liberty Bankers Life	Securian
Athene	Lincoln Financial Group	Security Benefit
Athene National	Lloyds of London	Sentinel Security Life
Atlantic Coast Life	LSW/National Life Group	SILAC
AXA Equitable Life	Mass Mutual	The Standard
Banner Life (Legal & Gen)	Mass Mutual Ascend	Symetra
Clearspring Life and Annuity	(formerly Great American)	Transamerica
Co. (formerly Guggenheim Life)	Met Life	Upstream
Columbus Life	Mutual of Omaha	US Life
Corebridge	Mutual Trust Life	Venerable (Formally VOYA)
Delaware Life	Nassau RE	W&S Financial Group
Equitrust	National Guardian Life	William Penn Life
ExamOne	National Western Life	(Legal & Gen.)
F&G Life	Nationwide	Other:_____
Foresters	New York Life	Other:_____
Genworth	North American	
Gerber Life	Oceanview	
Guaranty Income Life	OneAmerica	
Insurance Co., a Kuvare Co.	Oxford Life	
(GILICO)	Pacific Life	

Signed at _____ this _____day of _____20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

Date of Birth_____ Social Security Number _____