

International Brokerage Agencies, Inc.
Impaired Risk Department
Informal Inquiry

Not an application for insurance

| |
|-------------------|
| Agent Name: _____ |
| Address: _____ |
| _____ |
| Phone: _____ |

| | | | | | | |
|--|------------|---|----------------------------------|--|----------------|-----|
| Full Name | | Sex M <input type="checkbox"/> F <input type="checkbox"/> | Date of Birth | Height | Weight | SSN |
| Present Address | | | | Type of Business/Occupation | | |
| Have you ever used any form of tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | Has use been Discontinued? Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| If yes, list type and amount: | | | | If yes, explain: | | |
| Proposed Insurance Amount \$ | | | | Plan: Term <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> SURV <input type="checkbox"/> | | |
| Have you ever been declined <input type="checkbox"/> rated <input type="checkbox"/> ? | Company(s) | Year | Reason | | Rating | |
| Please indicate with a check (✓) those companies that have reviewed this case in the last year: <input type="checkbox"/> GE Life & Annuity <input type="checkbox"/> Manulife Financial <input type="checkbox"/> State Life <input type="checkbox"/> U.S. Financial <input type="checkbox"/> United of Omaha | | | | | | |
| Medical Information | | | | | | |
| Illness/Treatment | | Onset | All Doctors Consulted | | Last Follow-up | |
| | | | Please include address and phone | | | |
| | | | Please include address and phone | | | |
| Hospitalization | | Date | Illness | | Duration | |
| Please include address and phone | | | | | | |

Has any immediate family member had cancer, diabetes, high blood pressure, heart disease, or kidney disease? Yes No

If yes, please identify family member, disorder, and age deceased: _____

AUTHORIZATION TO OBTAIN INFORMATION

Please furnish: International Brokerage Agencies, Inc., American General Life Insurance Company, First Colony, GE Life & Annuity, Manulife Financial, North American Company, Old Line Life Insurance Company, Security Connecticut, United of Omaha, State Life, U.S. Financial, or their legal representative and reinsurers any information they request.

I (We) acknowledge that I (we) have received written notice that, as part of your procedure for processing my (our) insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with my (our) neighbors, friends, or others with whom I (we) have an acquaintance. This inquiry includes information as to my (our) character, general reputation, personal characteristics, and mode of living. I (We) know that I (we) have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confidential. The Companies named above may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange in behalf of its members. If you apply to another Bureau member company, the Bureau, upon request will supply such company with the information in its file.

Upon receipts of request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance 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 number (617) 426-3660.

The Companies named above may also release file information to other life insurance companies where you may apply for life or health insurance, or to whom a claim may be submitted.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give the companies named above any such information.

A photographic copy of the authorization shall be as valid as the original. By my (our) signature, I (we) indicate that we have retained a copy of this information.

Date

Name of Proposed Insured (Print or Type)

Agent (Print Name)

Signature of Proposed Insured