



Personal Information

Name _____ DOB _____ Gender Male Female
 Address _____ Country of Citizenship _____
 City _____ State _____ Zip _____ Occupation _____
 Phone# _____ SSN _____ Annual Income \$ _____ Net Worth \$ _____

Proposed Coverage

Coverage Amount \$ _____ Proposed Plan: Term Universal Life Whole Life
 Universal Life with LTC Variable

Medical History & Physician Information

Primary Care Physician	City, State & Phone Number	Date Last Seen	Reason for Visit

- Build: Height _____ ft _____ in Weight _____ lbs
- In the past 12 months, have you gained or lost more than 10lbs? If yes, how much? _____ gained _____ lost
- Have you ever had any of the following? If yes, provide details below.
 - a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke or any other disorder of the heart or blood vessels? Yes No
 - b) Diabetes, elevated blood sugars, glucose intolerance or disease of any gland? Yes No
 - c) Mental or emotional disorder, depression, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? Yes No
 - d) Arthritis, gout or any bone, joint, muscle or skin disorder or skin cancers? Yes No
 - e) Asthma, bronchitis, pneumonia, emphysema or any lung disorder? Yes No
 - f) Hepatitis, ulcer, colitis or other disease of the liver, pancreas, stomach or bowel/colon? Yes No
 - g) Prostate or testicular disease? (Males) Yes No
 - h) Uterine, cervix, ovary or breast disease? (Females) Yes No
 - i) Anemia, leukemia, clotting disorder, platelet or other blood disorder? Yes No
 - j) Urinary tract disorder, kidney, sugar, protein or blood in the urine? Yes No
 - k) Cancer or tumors? Yes No
 - l) Any hospital admission, surgery, emergency room visit or outpatient surgery? Yes No
 - m) Any other health impairment or medical condition related to this risk evaluation? Yes No

4. List all medications including over-the-counter and supplements _____

Q#	Additional Physician- Name, City, State & Phone #	Dates Seen & Reason for Visit/Diagnosis	Treatment & Results

Family History

	Current Age	Age at Death	Cause of Death if Applicable	History of Cardiovascular Disease? Provide Detail	History of Cancer? Provide Detail
Mother					
Father					
Brother(s)					
Sister(s)					

Lifestyle

1. Tobacco/Nicotine

Have you ever smoked cigarettes? Yes No If yes, provide frequency and date of last use _____

Have you ever used other products containing tobacco or nicotine? (ex: cigars, pipe, snuff, nicotine gum/patch, e-cigarette)

Yes No If yes, indicate type, frequency and date of last use _____

2. Marijuana

Do you use marijuana? Yes No If yes, indicate frequency and date of last use, check all that apply _____

Medicinal Recreational Inhaled Edible Topical Other _____

3. Alcohol

Do you consume alcohol? Yes No If yes, provide type, quantity and frequency _____

Has a doctor ever recommended that you decrease your alcohol consumption? Yes No

Have you ever received treatment (inpatient or outpatient) for alcohol or drug use?

Yes No If yes, provide details and dates _____

4. Exercise

Do you exercise regularly? Yes No If yes, provide type and frequency _____

5. Driving

Have you had 2 or more moving violations in the last 5 years? Yes No If yes, provide details and dates _____

Have you ever received a DUI/DWI? Yes No If yes, provide details and dates _____

6. Financial

Have you declared bankruptcy or been convicted of a felony offense in the last 10 years?

Yes No If yes, provide details and dates _____

7. Hazardous Activity

Are you a private pilot? Yes No If yes, do you have an IFR? Yes No

Hours flown as pilot in command _____ Hours flown per year _____ Hours anticipated in next 12 mo. _____

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

Scuba Diving Sky Diving Mountain Climbing Auto/Motorcycle Racing Other _____

Social

List any hobbies, clubs, church or volunteer groups, boards, charities that you are actively involved with:

Travel

Do you travel regularly? If yes, provide frequency, purpose, to which countries and any future travel plans:

Inforce Coverage Details

List all inforce coverage below:

Carrier	Coverage Amount	Inforce? (Y/N)	Rate Class	Year Issued	To Be Replaced? (Y/N)

Agent Name: _____

Date: _____

HIPAA AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

Purpose of Authorization:

The purpose of this authorization is to determine my eligibility for **LIFE INSURANCE PRODUCTS** or related services or conduct other legally permissible activities that relate to any insurance company or service provider listed below.

HIPAA Authorization:

I hereby authorize any licensed physician, medical practitioner, consulting physician, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, pharmacy related service organization or other 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 disclose any and all such information regarding diagnosis, treatment, prognosis and consultations to the life insurance companies and servicing agencies listed on this form along with their reinsurers or providers at the time of my signature. Furthermore, I authorize the release of privileged information such as but not limited to alcohol and/or drug treatment, HIV/AIDS treatment and psychiatric records. Treatment, payment, enrollment in a health plan or eligibility for health insurance benefits may not be conditioned on my signing this authorization. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency utilized by the insurance company to collect and transmit such information. I acknowledge that the information to be disclosed may be protected under State and Federal privacy laws and regulations. A photocopy of this authorization shall be as valid as the original. I have received a copy of the Fair Credit Reporting Act Notification and the Exchange of Information (MIB) disclosure. I understand that I may receive a copy of this authorization. I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Life Insurance Companies, Servicing Agencies and Writing Agents authorized to receive/transmit information under HIPAA

guidelines are: AgencyONE, Abacus Settlements, LLC, Allianz, American General Life Insurance/U.S. Life, American National/ANICO, Appel Insurance Advisors, LLC, APPS, Ashar Group, LLC, AVS Underwriting, LLC, AXA Equitable/MONY, Banner Life/William Penn, Coventry, EMSI, Eugene Cohen Insurance Agency, Evergreen Settlements, ExamOne, Exceptional Risk Advisors, LLC, Express Imaging Services, Fasano Associates, Fortamus, Gen Re, Global Atlantic Financial Group, Guardian, GWG Life, Habersham Funding, LLC, IMG Paramed, Inc., ITM|TwentyFirst, Jet Stream, John Hancock, Leaders Group, LifeMark Partners, Lincoln Financial Group, Lloyd's of London, LTCI Partners, Maple Life Financial, Mass Mutual, MetLife, Minnesota Life/Securian Life, Nationwide, New York Life, North American, Ohio National, OneAmerica, Pacific Life Insurance Company, Pacific Life & Annuity Company, Pan-American Assurance Company, Penn Mutual, Principal Life Insurance Co, Principal National Life Insurance Co, Protective Life Brokerage, Protective Life & Annuity, Prudential, Reliastar Life Insurance Company, Reliastar Life Insurance Company of NY, SBLI, Security Life of Denver Insurance Company, Symetra, Transamerica, United of Omaha/Mutual of Omaha, Voya Financial, Welcome Funds, Inc., Zurich Life, Zurich American Life Insurance Company.

***My writing agent, _____, and his/her agency, _____, are also authorized to receive or transmit information under HIPAA guidelines.**

I, the undersigned, hereby authorize any and all medical practitioners, physicians, hospitals, clinics and custodians or anyone else located at:

Medical Facility: _____
Facility Address: _____
Date of Services: _____
Contact Person: _____

To release records and information regarding the Proposed Insured listed below to and exchanged between the parties listed above and:

AgencyONE
11200 Rockville Pike, Suite 500
Rockville, MD 20852
Phone: 301.803.7500
Contact Person: _____

Duration:

Unless otherwise revoked, I agree this authorization shall remain valid for the lifetime of the undersigned, absent any provisions of any applicable state statute or regulations to the contrary, in which event it shall remain valid for 24 months or the maximum period permitted there under. I understand that I may revoke my authorization at any time by submitting in writing request of revocation to: AgencyONE, Chief Underwriter, 11200 Rockville Pike, Suite 500, Rockville, MD 20852. However, any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

Proposed Insured **PRINT** Proposed Insured **DOB** Proposed Insured **SIGNATURE** **DATE**

FOR CLIENT USE

The Life Insurance Exam Process Made Easy

The exam process should not be taken lightly as it can have a **direct impact** on your underwriting offers and life insurance **premium**. There are simple measures you can take to PREPARE your body for the best possible results. In the days leading up to your exam, it is vital that you **HYDRATE** with NON-caffeinated fluids, take all medications as prescribed, and be mindful of your diet. Get plenty of sleep and reduce stress as much as possible. Here are some additional tips:

1. **Morning appointments:** Morning exams are best as people tend to be more relaxed. Stress can falsely elevate blood pressure and pulse rates.
2. **Fasting:** Recommend fasting 12 hours prior to having your blood drawn as non-fasting blood can produce abnormal results on certain tests. Please also drink one large glass of water prior to your appointment since a urine sample will be collected.
3. **Caffeine:** Caffeine is a stimulant that elevates blood pressure and pulse rate. It also dehydrates the body, so please do not consume caffeine prior to your exam.
4. **Alcohol:** Alcohol can affect exam results and should be avoided at least 24 hours prior to your exam.
5. **Salt:** Sodium causes fluid retention which raises blood pressure and can affect blood/urine results. Limit salt intake for several days prior to the exam and stay hydrated.
6. **Smoking:** Smoking cigarettes raises your blood pressure. We advise smokers not to smoke prior to the exam. Be prepared to disclose any cigar, e-cigarette, dip, chew, Nicorette use, etc. with dates. Nicotine testing will occur. If you smoke or consume **MARIJUANA**, it is important you disclose the amount and frequency. Some companies will test for THC.
7. **Exercise: AVOID exercising 48 hours prior to the exam.** Physical activity such as running, jogging, or weightlifting can adversely affect blood and urine results.
8. **Medical History:** It is **VERY IMPORTANT** to give your complete medical history. Be prepared with an accurate list of your doctors' names, addresses, dates visited, diagnoses, and treatments.
9. **Prescription Drugs & Over-The-Counter Medications:** Prepare a complete list of all prescription medications, including those taken only on an "as-needed" basis. Provide dosages, dates prescribed, and the prescribing physician's name. Over-the-counter medications including megadose vitamins, Tylenol, supplements, and decongestants should also be noted as they may affect blood or urine results.
10. **Urine specimen:** A urine specimen will be collected. You may wish to request that the urine sample be collected at the beginning of the exam process. The most common abnormal finding is protein in the urine, usually resulting from exercise prior to lab testing. See smoking (#6) and exercise (#7) referenced above.
11. **Blood:** Bloodwork will be required. If you are nervous about the blood draw, request this to be completed BEFORE blood pressure and pulse are measured. ***Please refer to *Accessing Your Lab Results On-Line/Authorization to Release for instructions to retrieve your results**** Please forward the results to your agent upon receipt. These values directly impact underwriting offer(s).
12. **Timing:** Please allow at least 30 minutes for a full exam, perhaps longer if an EKG is involved. A Senior Supplement may be required for clients over the age of 70. Guidelines to help prepare are available upon request.

The underwriting process includes the insurance exam, medical records, and potential letters from some of your physicians. Please assist in this process when possible. We are all on the same team! ***REMEMBER, EVERY PHYSICIAN VISIT AFTER THE LIFE INSURANCE EXAM MUST ALSO BE DISCLOSED TO YOUR AGENT AND COULD AFFECT UNDERWRITING DECISIONS.**

FOR CLIENT USE

Laboratory testing is a vital part of underwriting your life insurance application. ExamOne and Clinical Reference Laboratory (CRL) both offer a secure online platform that allows you to access your lab results for one year following your exam.

Why Access My Labs Online?

- Convenience - No paper forms to print and no waiting for your results to be mailed to you.
- Online Availability - Results can be obtained quickly and securely from any internet-enabled device. If your results are still being analyzed at the laboratory, you will have the option to be notified when the information becomes available.
- Flexibility - Once the results are available, you can print or save them for your records and share with your agent and/or personal physician.
- Security - CRL and ExamOne utilize state-of-the-art security measures. Keeping your lab results protected, secure and confidential throughout the process is the top priority.

How Do I Access My Results?



ExamOne

1. Go to <https://applicant.ExamOne.com>
2. Click 'Register Here' and include the bar code number from the front of your 'Important Information' brochure.
3. You will receive an email notification when your results become available.
4. Follow the link in the email and login using the username and password.
5. Read and accept the Terms of Use.
6. View, save or print your results!
7. **Please contact ExamOne directly with questions related to accessing your lab results- 877.933.9261, Option 1.**

Clinical Reference Laboratory

1. Go to www.AccessMyLab.com and enter your slip ID located on the consent form provided by the examiner.
2. When prompted, enter the last 4 digits of your **cell phone** number. Landline phone numbers do not work.
3. A PIN will be provided via text code or voice message from their automatic system.
4. Enter the PIN to view your lab report online.
5. View, save or print your results!
6. **Please contact CRL directly with questions related to accessing your lab results- 800.445.6917.**

For general questions about your life insurance application process, please contact your agent.

Processing times may vary. Please allow up to 10 business days before results become available.