Insurance Designers Informal Application

Insurance Designers of Dallas
7557 Rambler Rd., Suite 950 Dallas, TX 75231
Ph. 214-696-9756 / Fax 214-368-0308 www.insdesign.com

Insurance Designers, LLC and it's Partner and Affiliate offices comprise a full service brokerage organization committed to comprehensive insurance analysis for clients. Our on-site underwriting program and informal application process eliminates excess applications, examinations and excessive MIB reports. Learn how you are rated tentatively so you can start with the best potential formal application first!

Instructions

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages. If additional space is needed, use page 4 or add a separate page. Complete, accurate information produces the most competitive carrier offers. Because of the significant expense involved in purchasing medical records, IDA's underwriting staff has final discretion regarding pre-purchase of client's medical records.
If submitting for informal Survivorship quotes, please complete a separate application for each proposed insured and submit together.

1. Broker/Advisor Information

Name _____ Firm/Agency_____

Phone_____ Fax_____ Email_____

2. Case Design Information

Check one; Single Life case Survivorship (complete 2 apps) 1st to Die (complete 2 apps)

Check one) Universal Life Variable Universal Life Whole Life (Term Period) Survivorship UL Other_____

Death Benefit Amount _____If no lapse, carry guarantees to age_____

Riders_____

Premium design (i.e. lump sum, 1035, limited pay)_____

Purpose of Coverage (i.e. estate plan, buy-sell, etc) _____

_____

3. Proposed Insured Information

Proposed Insured _____
Last Name First Name MI Daytime Phone

Social Security Number _____-_____-_____ Date of Birth _____

(Check one) Male ☐ Female ☐

Drivers License No. _____ State of issue _____

Residence Address _____
Street City State Zip Code

Employer _____ Position _____

Duties_____ Year in this occupation_____

4. Foreign Travel/Citizenship

U.S. citizen? _____ How Long? _____ If no, country of citizenship _____ Dual Citizenship?_____

Have you traveled outside North America or Western Europe in the last 2 years or intend to do so in the next 2 years? _____ If yes, list dates traveled (or anticipated traveling dates), duration, country and purpose of trip on page 4.

5. Existing and Pending Insurance

A) Year issued Company Amount Purpose Keep or Replace?

B) Have you ever been rated substandard, declined or postponed when applying for Life, LTC or DI insurance?
Please include date and explain:

6. Lifestyle and Avocation Information

A) Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years? If yes, hours flown last year _____ Anticipated hours next 12 months _____
License type_____ Date of last flight_____ Aircraft type & purpose_____
B) Have you engaged in or plan to engage in scuba or skin diving?
If yes, Number of dives last year_____ Anticipated dives next 12 months_____ Maximum depth_____
Where do you dive? (i.e. rivers, open ocean, etc)_____
Purpose of diving (i.e. vacation, commercial, instructor)_____
C) Have you engaged or plan to engage in any type of motor vehicle or boat racing?
If yes, please provide complete details on license type, circuit, frequency

D) Have you engaged in or do you plan to engage in any mountain climbing, sky diving or any other hazardous sports or activities? If yes, please provide details immediately below or on page 4 if more space is needed.

E) Have you had any moving violations or been cited for driving while impaired?
Please provide details and date of occurrences

F) Have you declared bankruptcy, or been convicted of a felony offense in the last 10 years?
Please provide details

G) Do you use any tobacco or nicotine products presently?
How many years? Type & Amount per day Any plans to quit?

H) Have you ever used tobacco in any form? (check one) cigarettes cigar chew pipe snuff
Date last used Type & Amount per day

J) Do you consume drugs other than prescribed by a physician?
Please provide details

K) Do you consume alcohol? If yes, please specify type, quantity and frequency

L) Have you ever been treated for, or recommended to seek treatment for alcohol or drug abuse?
Please provide details

M) Do you exercise regularly? If yes, please specify type, duration and frequency per week

N) Do you manage your diet? Please explain

7. Medical Information

A) Height Weight Any change greater than 10 pounds in the last 2 years?
If yes, please explain

B) Medications Please list prescription and non– prescription medications used below be sure to include;
Date started Medication & Dosage Purpose Prescribing Doctor's name Results of use

8. Medical Care Providers Information

Please provide complete information for all doctors and health care facilities that have consulted with, or treated you in the last 10 years. If additional space is needed, please continue on page 4 or add a separate page.

Primary Care Physician's

Name_____ Phone # _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

Specialist or other Care Provider _____Phone # _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

Specialist or other Care Provider _____Phone #__ _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

9. Medical Questions

Please provide details (diagnosis, onset date, duration of condition, treatments and current status) to any "Yes" answers on the next page

Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have;

YES - NO

A) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke (TIA), irregular heartbeat or any other disease or disorder of the heart or arteries?
B) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?
C) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
D) Arthritis, gout or any bone, joint, muscle or skin disorder?
E) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
F) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
G) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
H) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
I) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
J) Cancer or tumors of any kind, malignant or benign?
K) Any other health impairment or medically treated condition not yet mentioned?
L) Been advised to seek treatment for any impairment or condition that has not been treated?

General and Medical Question Responses/Details

Please provide the question number and details as appropriate. For Medical questions, Please provide as much detail as possible regarding diagnosis, onset date, duration of condition, treatments, current status and caregiver/ provider with contact information (if different from those listed in section 8.)

Question #	Dates	Details

INSURANCE DESIGNERS

Health Information Authorization

This is a HIPAA Compliant Authorization

Who is Authorized to Disclose Information

I authorize any health plan, doctor, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical prescription drug databases, medical facility, Veterans Administration, care providers or evaluators, or other health care provider that has provided treatment or services to me or on my behalf ("My Providers"), and any other medical or insurance organization, institution or professional, or consumer reporting agency, to disclose my Health Information to Insurance Designers of American ("IDA") and its Affiliated Agencies, who is authorized to disclose my Health Information to any of IDA's Authorized Insurance Carriers listed at the end of this Authorization for the purpose of obtaining insurance.

Health Information to be Used or Disclosed

"Health Information" includes any information about me, my entire medical record and any other health information concerning me, without restriction. This includes medical records, prescription drugs and information on diagnoses and/or treatment relating to Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), sexually transmitted disease, mental illness, and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any of My Providers and other entities or persons referred to above to release and disclose my entire medical record without restriction to IDA and its Affiliated Agencies.

Who May Request Information

My Health Information may be disclosed to Insurance Designers of America, its Affiliated Agencies and its agents, employees and representatives ("IDA"), including, but not limited to, Release Point, Examination Management Services, Incorporated (EMSI) and APS Workflow, Inc.; its insurance support organizations; its affiliates and reinsurers; and MIB, Inc. ("MIB").

Purpose

Health Information is to be disclosed under this authorization so that IDA may do any of the following: 1) underwrite any insurance I am or will be applying for with any of the Authorized Carriers. I further authorize IDA to disclose my Health Information to any consumer reporting agency such as the Medical Information Bureau (MIB, Inc.).

• This authorization shall remain in force for 24 months following the date of my signature below, unless state law imposes a shorter duration.

• I understand that I have the right to withdraw this authorization in writing, at any time, by sending a written request to: Insurance Designers of America, 1450 Greene Street, Suite 221, Augusta, GA 30901, Attention: Privacy Official.

• I understand that a withdrawal is not effective if any of My Providers has relied on this authorization or to the extent that an Authorized Carrier has a legal right to contest a claim under an insurance policy or to contest the policy itself.

• I understand that any information disclosed pursuant to this authorization may be re-disclosed, to the extent allowable under federal law and no longer covered by certain federal rules governing privacy and confidentiality of health information.
• A copy of this authorization is as valid as the original.
• I understand that if I refuse to sign this authorization, IDA may not be able to process my informal application with any of its Authorized Carriers.
• I understand that IDA will provide me with a copy of this authorization.

This authorization is for the release of my Health Information to the following IDA Affiliated Agency:

Name_____

Address _____ City _____ST_____ Zip _____

IDA's Authorized Insurance Carriers and Insurance Support Organizations

Authorized Insurance Carriers: Accordia Life and Annuity Company/Global Atlantic Financial Group, Allianz Life Insurance Company of North America, Allianz Life Insurance Company of New York, AIG Life Insurance Company/US Life Insurance Company, American National Life Insurance Company, Assurity Life Insurance Company, Banner Life Insurance Company/William Penn Life Insurance Company of New York, Columbus Life Insurance Company, Equitable Life Insurance Company, John Hancock Life Insurance Company (U.S.A.) John Hancock Life & Health Insurance Company, John Hancock Life Insurance Company of New York, Lafayette Life Insurance Company, Lincoln National Insurance Company, Lincoln Life & Annuity Company of New York, Minnesota Life Insurance Company and Securian Life Insurance Company (NY), Mutual of Omaha Insurance Company/United of Omaha/Companion Life, Nationwide Mutual Insurance Company and Affiliated Companies, New York Life Insurance Company, North American Company for Life and Health Insurance, Pacific Life Insurance Company, Principal Life Insurance, Principal National Life Insurance Company, Protective Life Insurance Company, Protective Life and Annuity Insurance Company, The Prudential Insurance Company of America, Pruco Life Insurance Company (except in NY and/or NJ), Pruco Life Insurance Company of New Jersey (in NY and/or NJ), Reliance Standard Life Insurance Company, Sagicor Life Insurance Company, SBLI (Savings Bank Mutual Life Insurance), State Life/ OneAmerica, Symetra Life Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company of New York, Western Reserve Life Assurance Company.

Authorized Insurance Support Organizations: Insurance Designers of Dallas and its Affiliated Agencies, APPS/Portamedic, ExamOne/Quest Diagnostics, JetStream, Superior Solutions, Express Imaging Services

_____ _____ _____

Printed Name of Applicant Date of Birth Last 4 Digits of SSN

_____

Signature of Applicant