The Stamm Agency

Informal Insurability Inquiry

This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

PRODUCER INFORMATION (this section must be completed)

Name	Producer Number
Phone	Email Address
Have you submitted this case previously? ☐ Yes ☐ No	

CLIENT HISTORY (this section must be completed)

Client Name			State	
☐ Male ☐ Female	Date of Birth	Age	Height	Weight
Average weight change in the past 12 months		Occupation		
Is the client a Foreign National? ☐ Yes ☐ No		If yes, list country of citizenship		
Has the client traveled outside the United States? ☐ Yes ☐ No		If yes, list the countries and dates visited		
Green Card? ☐ Yes ☐ No				
Type of Visa				

REQUESTED COVERAGE (this section must be completed)

☐ Universal Life ☐ Survivorship ☐ Variable Life ☐ Whole Life ☐ LTC Rider ☐ Term, Level Period _____

Face amount desired?	If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? _____

Has the case been submitted to other companies in the last 12 months? ☐ Yes ☐ No If Yes, list companies, dates, and action taken

TOBACCO/NICOTINE USAGE (this section must be completed)

Has your client ever smoked cigarettes:

☐ Yes ☐ No If yes, date of last usage:

Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐ Yes ☐ No

If yes, provide types and last date of use:

MARIJUANA & CBD OIL USAGE (this section must be completed)

Does your client use marijuana ☐ Yes ☐ No If yes, complete the following:

Purpose ☐ Recreational/Social ☐ Medicinal Frequency_____ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Inhaled Date Last Used _____

Does your client use CBD oil? ☐ Yes ☐ No If yes, complete the following:

Frequency_____ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Topical Date Last Used _____

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The Stamm Agency
7200 W. Camino Real, Suite 102, Boca Raton, FL 33433 / Phone: (561)368-6666

MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your client's primary care physician? When did your client last consult him/her? Any ongoing medical treatment?			
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below. ☐ Yes ☐ No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

DRUG AND ALCOHOL USAGE ☐ check here if this section is not applicable

Does your client currently drink alcohol? ☐ Yes ☐ No

Type(s) of Alcohol _____

Date of last consumption _____

How much per week _____

Has your client ever drank substantially more than present? ☐ Yes ☐ No

If yes, when? _____

Has your client ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details _____

Has your client ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details _____

Type of drug(s) used _____ Date of last use _____

CORONARY ☐ check here if this section is not applicable

Date of diagnosis or first chest pain	Number of diseased vessels	
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)		
Date of last stress EKG	Results	By whom?
Any pain since treatment/surgery?		

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CANCER ☐ check here if this section is not applicable

Exact name and location of cancer	Stage and grade
Who would have the pathology report	Date/details of treatment/surgery

DIABETES ☐ check here if this section is not applicable

Date of diagnosis	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details	
Does your client regularly test his/her blood glucose? ☐ Yes ☐ No	Results		Frequency
Latest result of glycohemoglobin (A1C) test _____mg%	Date_____		
Has your client been diagnosed with having protein and/or microalbumin in urine? ☐ Yes ☐ No			
Have your client ever had: Eye trouble ☐ Yes ☐ No	Heart trouble ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No	
Have your client ever had: Kidney trouble ☐ Yes ☐ No	Neuritis/Neuralgia ☐ Yes ☐ No	Insulin reactions ☐ Yes ☐ No	

MENTAL DISORDERS/DEPRESSION/ANXIETY ☐ check here if this section is not applicable

Date of diagnosis	Hospitalization ☐ Yes ☐ No	Suicide attemp(s) ☐ Yes ☐ No	Currently employed ☐ Yes ☐ No
Medications			

SLEEP APNEA ☐ check here if this section is not applicable

Date of diagnosis	Is a CPAP used every night ☐ Yes ☐ No	Date of last sleep study
Sleep study results ☐ Mild ☐ Moderate ☐ Severe	Was surgery done ☐ Yes ☐ No	If yes, type of surgery

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Is your client a private pilot? ☐ Yes ☐ No If yes, provide details.	How many total hours has your client flown as Pilot in Command?_____	How many hours does your client fly per year? _____	Does your client have an IFR (instrument flight rating) ☐ Yes ☐ No

Does your client participate in the following activities? (check those that apply)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving
☐ Mountain Climbing ☐ Hang Gliding ☐ Auto/Motorcycle Racing ☐ Other_____

DRIVING HISTORY ☐ check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Multiple Sclerosis, TIA/CVA, etc.)? If so, please describe below and include additional pages if more space is needed.

Impairment Not Listed	Date of Diagnosis	Treatment Medication(s)	Date of Last Follow-Up Test Results

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that any life Insurance companies represented by The Stamm Agency in my behalf, their reinsurers, any insurance support organizations and the authorized representatives of these companies may need to collect Information on me in regard to proposed life insurance coverage. Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, Insurance or Reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources and employers to furnish to the insurance companies the types of Information specific In this Authorization upon presentation of this Authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to The Stamm Agency and Its affiliated corporations.

The types of Information will Include Information about drugs, alcoholism, my mental and physical health, other insurance coverage, participation In hazardous activities, character, general reputation, mode of living, finances, occupation and other personal characteristics.

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

Since The Stamm Agency and Its affiliated corporations are wholesale facilities and act primarily as a conduit to facilitate a relationship between the proposed Insured's agent and life insurance companies, the proposed Insured agrees that In the event of any litigation instituted by the proposed Insured and/or policy-owners, beneficiaries, or assignees of policies which are issued on the proposed insured's life that the proposed insured will pay reasonable attorneys fees incurred by The Stamm Agency or any of its affiliated corporations in defense of the aforesaid litigation or in any representation related to the aforesaid litigation. I also understand that if I make application to a life Insurance company as a result of a tentative offer made by The Stamm Agency and its affiliated corporations, neither The Stamm Agency and its affiliated corporations nor my agent has any right to effect any coverage and that the coverage will only be In effect when a policy is issued, the premium has been paid and all conditions precedent are satisfied. I recognize the significance of the foregoing and accept the same. I also recognize that The Stamm Agency and its affiliated corporations shall not be liable for any representations made by my agent unless these representations are confirmed In writing by The Stamm Agency and its affiliated corporations. This Authorization will be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization. A photographic copy of this Authoriza-tion shall be as valid as the original.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices.

THIS IS NOT AN APPLICATION FOR THE ISSUANCE OF LIFE INSURANCE

Signed at _____ **this** _____ **day of** _____, **20** _____

(City, State)

I acknowledge that I have read the foregoing terms and understand the same.

_____ _____

Witness · Agent Signature **Proposed Insured Signature**

Corebridge
American General Life
United States Life Ins. Co.
Allianz Life Ins. Co. of NA
American Equity Inv. Life Ins. Co.
American National
American National of NY
Ameritas Life Ins. Corp.
Assurity Life
Athene Annuity & Life Co.
Athene Annuity & Life Ass. Co. of NY
Augustar Life
Brighthouse Life Ins. Co.
Brighthouse Life Ins. Co. of NY
Delaware Life
Fidelity Security Life
Foresters Financial
Gerber Life
Global Atlantic
Forthought
Guarantee Income Life Ins. Co.
Guardian Life Insurance Company
Illinois Mutual
Intergrity Life Ins. Co.
John Hancock USA
John Hancock of NY
Legal & General American
Banner Life Ins. Co.
William Penn of NY
Lincoln Financial
Lincoln Life & Annuity Co. of NY
MassMutual/MMSD
MassMutual Ascend (Annuity)
Mutual of Omaha
United of Omaha
National Guardian Life
National Integrity Life
National Life Group
Life Ins. Co. of the Southwest
National Life Insurance Company
Nationwide
New York Life
North American co. for Life & Health
Oceanview Life and Annuity
OneAmerica
Pacific Life - Lynburg
Penn Mutual Life Ins. Co.
Principal Financial Group
Principal National Life
Principal Life
Protective Life
Protective Life and Annuity
Prudential Financial
Pruco Life Ins. Co.
Reliance Standard
Sagicor
Savings Bank Life Ins. Co. of MA
Securian Life
Minnesota Life
Security Mutual Life Ins. Co.
Symetra Life
First Symetra
The Standard
The Standard Life Ins. Co. of NY
The Stamm Agency
Tellus Brokerage Connections
Thrivent
Transamerica Life Ins. Co.
Transamerica Financial

THE STAMM AGENCY HIPAA AUTHORIZATION IS ALSO REQUIRED

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____ , authorize _____
(Patient or Legal Representative) (Name of physician/ health care provider releasing records)

To disclose to:

The Stamm Agency / Express Imaging Services. Inc../Parameds.com

The Stamm Agency
7200 W. Camino Real
Suite 102
Boca Raton, FL 33433
(561) 368-6666

Express Imaging Services, Inc.
PO Box 778
Torrance, CA 90508
(888) 846-8804

Parameds.com
120-10 Queens Blvd
Kew Gardens, NY 11415
718-575-2000

The following protected health care information:
Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.

Entire medical records for specific date(s) of service: From: _____ To: _____

Only the following specific information:

_____
_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below: _____ please initial

- Psychological/ Psychiatric Conditions
- Drug and/or Alcohol Abuse diagnosis and/or treatment
- HIV/AIDS diagnosis and/or testing
- Sexually transmitted disease(s) diagnosis and/or testing
- Genetic testing

List any restrictions _____

This protected health information is to be disclosed under this Authorization so that The Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with The Company.

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has legal right to contest the policy or claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorized form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in 24 months and that a copy of this authorization is as valid as the original.

Signature of Patient or Legal Representative(s): _____
(Note: If patient is a minor child, both parents may be required by law to sign)

Date: _____ Printed Name(s): _____

Relationship to Patient: _____
(if signed by other than patient)