Informal Inquiry

Main Office
Windsor Insurance Associates, Inc.
20301 Ventura Blvd. Suite 225
P.O. Box 4011
Woodland Hills, CA 91365
ph. 800.410.9890
fx. 818.594.5063
email: firstname@windsorinsurance.com

Windsor Central
12804 Lantana Ridge Ct
Austin, TX 78732
ph. 512.436.9706
fx. 512.857.8205
justin@windsorinsurance.com

Windsor East
47 Fifth Avenue
Nyack, NY 10960
ph. 845.358.5204
fx. 845.358.4245
marty@windsorinsurance.com

PRELIMINARY INQUIRY

PERSONAL HISTORY – PROPOSED INSURED

Name _____ Male ☐ Female ☐

Social Security Number _____ U.S. Citizen: Yes ☐ No ☐

Address _____

City _____State _____ Zip _____

Work Phone _____ Home Phone _____

Date of Birth _____ Age _____ Height _____ Weight _____

Occupation _____ Drivers License #/State_____

Do you currently use: Cigarettes Yes ☐ No ☐ Cigars Yes ☐ No ☐ Other Yes ☐ No ☐

If yes for Cigars, frequency/quantity_____ If yes for Other, provide details_____

If no for cigarettes, years/months last smoked if less then 3 years_____

REQUESTED PLAN OF INSURANCE

☐ Universal Life ☐ Term ☐ Survivorship (☐ UL/ ☐ VUL) ☐ Variable

Face amount desired $_____ Reason for insurance? _____

OTHER INSURANCE

Total amount in-force _____ Date of last application_____

Any insurance being replaced ☐Yes ☐No Face amount replaced _____

Carrier(s) being replaced _____

PERSONAL FINANCIAL INFORMATION

Net worth:_____ Income: Earned_____ Unearned_____

AGENT INFORMATION

Name _____ Social Security Number _____

Firm Name _____Phone number _____
Email address _____

MEDICAL HISTORY

Primary
Physician:_____
Name Address Phone

List all medical specialists that you have seen in the last 5 years.

Name & Specialty	*Address*	*Phone*	*Date of Visit*	*Reason for Visit*
1.				
2.				
3.				
4.				

List all current medications:_____

_____

Have you ever been diagnosed with or treated for any of the following (check all that apply)
If "Yes", please give details below.

❒ 1. Heart Attack
❒ 2. Heart Surgery
❒ 3. Heart Disease
❒ 4. Chest Pain related to cardiovascular disease
❒ 5. High Blood Pressure
❒ 6. Heart murmur
❒ 7. Stroke/TIA
❒ 8. Cancer
❒ 9. Diabetes (not during pregnancy)
❒ 10. Lupus
❒ 11. Ulcerative colitis or Crohn's
❒ 12. Lung or breathing disorder
❒ 13. Kidney Disorder
❒ 14. Hepatitis / liver disorder
❒ 15. Nervous system disorder
❒ 16. Brain / spinal cord disorder
❒ 17. Depression
❒ 18. Alzheimer's or dementia
❒ 19. Other

Number	Treatment/ Prognosis	Date of onset / Date of Recovery	Treating MD name (address and phone if not above) If Hospitalized include name/address of hospital

Do your mother, father or sibling(s) have a history of cancer and/or heart disease? If Yes, please indicate type of history, date of onset, current age or age at death if deceased. _____

NOTICE TO PROPOSED INSURED(S)

Instructions to the Agent: This form must be given to the proposed insured before or at the time of signature.

FEDERAL FAIR CREDIT REPORTING ACT NOTICE

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors; business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The insurers named on the reverse side or their reinsurers 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 bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information they may have in your file. 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: P.O. Box 105, Essex Station , Boston, Massachusetts 02112; Phone (617) 426-366O.

Each named insurer or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INSURANCE INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. I authorize the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law. In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES. EACH INSURER NAMED HEREIN REQUIRES THE COMPLETION OF A FULL APPLICATION FOR ITS RESPECTIVE PRODUCT LINES.

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN & DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Proposed Insured: _____

Date of Birth: _____ Social Security Number: _____

Records and Information obtained will be disclosed between the insurance company or companies listed below, and Windsor Insurance Associates, Inc. producers, contractors, employees, representatives and affiliates.

INSURERS

Advanced Settlements	F&G Life	North American Company
AI Credit	Fasano	Pacific Life
Allianz	First Bank of Delaware	PFG
American General Life Companies	Genworth Life Insurance Companies	Phoenix Home Life
American National	Goldman Sachs	Polaris Capital
Ameritas (for SPIA products only)	Hartford Life Insurance Companies	Potomac Partners
AVS	Highland Capital Brokerage	Principal Financial Life Ins, Co.
Aviva USA	ING Life Insurance Companies	Protective Life Insurance Companies
AXA Equitable Life	InsCap	Prudential Life Insurance Companies
Bankers Life of New York	Institutional Life Services, LLC	Ridge Capital
Banner Life	Insurative	Sun Life Insurance Companies
Bragg	John Hancock Life Insurance Companies	21st Services
Brokerage Services, Inc.	Liberty (for SPIA products only)	Total Financial & Insurance Services
C2 Advisors	LifeStyle Settlement, Inc.	Transamerica Life Insurance Companies
Cambridge Financing Company (CFC)	Lincoln Benefit Life	Union Central
Centara Capital Management Group, Inc	Lincoln National Life Insurance Companies	United National Funding
CMS	Longmore Credit	United of Omaha
Companion Life	Metlife Life Insurance Companies	Universal Insurance Services
Concord Capital	Mutual of Omaha	US Life
Coventry First	Nationwide Insurance Company	West Coast Life
Credit Suisse	New York Life Insurance Companies	William Penn
EquityKey Real Estate Option, LLC	NIW	Windsor Insurance Associates, Inc.

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, (5) STD testing and treatment, (6) Genetic testing, (7) Sickle Cell testing and treatment, (8) lab results; (9) other insurance coverage (10) hazardous activities; (11) character; (12) general reputation; (13) mode of living; (14) finances; (15) occupation; and (16) other personal traits.

I understand that any Insurer named above, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect information for proposed insurance coverage.

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

Medical Facility: _____

Facility Address: _____

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

Requestor of Medical Information: _____

Requestor Address: _____

Broker/Agent/Agency/Firm: _____

Broker/Agent/Agency/Firm Address: _____

The Insurers named above and their reinsurers will use the information in order to determine whether I am insurable. The insurance producer may also use this information to help update and improve my insurance program.

Those parties named above may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) MIB; or (4) other persons who perform business, professional or insurance tasks for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use a secured internet-based system to store/access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This authorization will remain in effect for 36 months from the date of my signature below. I understand I may revoke this Authorization at any time by requesting such of my broker in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. 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). My authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by their 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 _____, (year)_____.

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative:

_____

Signature of Witness:_____

Complete if minor child is proposed for coverage:
Name of Minor Child: _____
Relationship of Representative to minor: _____