MAIN STREET PLANNING GROUP
Full Service Insurance Brokerage Firm

INFORMAL INQUIRY
This is not an Application for Insurance

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AGENT'S NAME: _____ **E-MAIL ADDRESS:** _____

PHONE NUMBER: _____ **FAX NUMBER:** _____

PROPOSED INSURED: _____ SEX: ❑M ❑F

SOCIAL SECURITY # _____ DATE OF BIRTH: _____ PLACE OF BIRTH: _____

RESIDENT STATE: _____ AMOUNT OF INSURANCE DESIRED: $_____

PLAN OF INSURANCE: ❑ WL ❑ UL ❑TERM _____yr ❑ SECOND TO DIE ❑ LTC ❑ DI

HAVE YOU SMOKED CIGARETTES IN THE PAST 12 MONTHS? ❑ YES ❑ NO HAVE YOU SMOKED CIGARETTES IN THE PAST 36 MONTHS? ❑ YES ❑ NO

DO YOU USE ANY OTHER FORM OF TABACCO PRODUCTS SUCH AS THE PATCH, GUM, CHEWING TABACCO, CIGAR, ETC? ❑ YES ❑ NO

IF YES, DESCRIBE USE: _____

HOW MUCH INSURANCE IN FORCE NOW? $ _____

HAS CASE BEEN SUBMITTED TO OTHER COMPANIES IN THE PAST 6 MONTHS? ❑ YES ❑ NO

IF YES, LIST COMPANIES: _____

LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:					
NAME OF COMPANY	FACE AMOUNT	YEAR	ISSUED? YES/NO	EXTRA PREMIUM OR RATING	REASON RATED OR DECLINED

Physician / Hospital Information

	Name, Address, Phone Number	Reason	Date
What Physician did you last consult? (Other than insurance examination)			
What Physicians have you consulted during the past 10 years?			
In what hospitals, clinics or sanitariums have you ever been treated			

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION. THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE.

I authorize _____ to give any information about me or my mental or physical health to the Company/and or its authorized agents to determine my eligibility for insurance and/or benefit payment. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as, hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It also includes motor vehicle records.

For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical records to the Company, excluding psychotherapy notes.

This Authorization may be revoked at any time by writing to us at the address listed above. The revocation will not be valid to the extent we relied on the Authorization to contest coverage. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance.

The Company may retain and disclose information to the Medical Information Bureau, reinsurers , or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure.

Once disclosed to the Company, the information will no longer be protected by the by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information.

This Authorization also applies to any member of my family proposed for coverage in the application and is valid for two years after the date below.

A copy of this Authorization will be provided to me by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original.

I have read and agreed to all the applicable terms of this form. I also understand this form in its entirety will be provided to the individual listed in the Authorization above in order to request medical information to determine eligibility for coverage.

Signature of primary proposed insured **X** _____ _____/_____/_____

(If age 15 or over, otherwise applicant) month day year

AIG/American General	Banner Life	Lincoln Life & Annuity Co NY	National Life of Vermont	Protective Life	Transamerica Life Ins. Co.
Allianz Life Ins. Co. / NY	Companion Life	Lincoln National	Co Nationwide	Prudential	United of Omaha
American National	Global Atlantic	Mass Mutual	New York Life	SBLI	Penn Mutual
Ameritas	John Hancock Life	MetLife/First Met Investors	North American	Security Mutual Life	US Life
Assurity Life	John Hancock NY	Minnesota Life Insurance	Pacific Life	Symetra	William Penn
Axa/Equitable	John Hancock USA	National Life	Principal	The Hartford	Zurich