HCB Informal Medical Questionnaire

Personal History—Proposed Insured

Name: _____ ☐ Male ☐ Female Phone number: _____

U.S. citizen? ☐ Yes ☐ No If no, country of citizenship: _____ Visa type: _____

Date of birth: _____ Birth state: _____ Height: _____ Weight: _____

Driver's license number: _____ Driver's license state: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Duties: _____

What is your annual earned income?_____ What is your annual unearned income?_____

What is your personal net worth?_____

Lifestyle

Have you ever used nicotine products? ☐ Yes ☐ No

If yes, complete the date last used and type of nicotine used: Date: _____ Type: _____

Do you currently use nicotine products? ☐ Yes ☐ No

If yes, please select type and indicate amount: ☐ Cigarettes ☐ Chewing tobacco ☐ Cigars ☐ Pipe

☐ E-cigarette ☐ Gum ☐ Lozenge ☐ Vaping ☐ Hookah ☐ Other: _____

Amount: _____ per ☐ day ☐ week

Do you currently use marijuana? ☐ Yes ☐ No

If yes, please indicate form used (ingested, smoked, etc.): _____

Number of times weekly: _____ monthly: _____

Did you lose or gain more than 10 pounds in the past year? ☐ Yes ☐ No

If yes, explain reason for weight change: _____

Do you engage in regular exercise? ☐ Yes ☐ No

If yes, list the type(s) of exercise: _____

How many times a week? _____ How long per occasion? _____

Any history or treatment of drug/alcohol use? ☐ Yes ☐ No

If yes, explain or complete alcohol/drug questionnaire: _____

Any history of moving violations? ☐ Yes ☐ No

If yes, explain or complete reckless driving questionnaire: _____

_____

Are you a pilot and/or do you participate in any activities such as scuba diving, rock climbing, motorcross, etc.?

☐ Yes ☐ No If yes, provide details: _____

Do you intend to reside or travel outside of the United States within the next two years? ☐ Yes ☐ No

If yes, please provide city, country, dates/duration, and purpose of all travel: _____

_____

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Medical History

Who is your personal physician?

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone number: _____

Date seen: _____ Reason/Diagnosis: _____

What other medical practitioners or specialists have you consulted during the past five years?
(Do not include insurance examinations.)

1. Name: _____ Address: _____
   City: _____ State: _____ Zip: _____ Phone number: _____
   Date seen: _____ Reason/Diagnosis: _____

2. Name: _____ Address: _____
   City: _____ State: _____ Zip: _____ Phone number: _____
   Date seen: _____ Reason/Diagnosis: _____

3. Name: _____ Address: _____
   City: _____ State: _____ Zip: _____ Phone number: _____
   Date seen: _____ Reason/Diagnosis: _____

4. Name: _____ Address: _____
   City: _____ State: _____ Zip: _____ Phone number: _____
   Date seen: _____ Reason/Diagnosis: _____

In what clinics or hospitals have you ever been treated?

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

Please list all current medications, purposes and doses (both prescribed and non-prescribed).

_____ Purpose: _____ Dosage: _____

_____ Purpose: _____ Dosage: _____

_____ Purpose: _____ Dosage: _____

Do you have any upcoming procedure or office visit planned with any physician? ☐ Yes ☐ No

If yes, please provide details: _____

Any cancer, cardiovascular, or diabetes history/deaths prior to age 60 among your parents or siblings? ☐ Yes ☐ No

If living, please provide age:	**If deceased, please provide age at death and cause of death:**	
Mother: _____	Mother: _____	Cause of death: _____
Father: _____	Father: _____	Cause of death: _____
Sibling: _____	Sibling: _____	Cause of death: _____
Sibling: _____	Sibling: _____	Cause of death: _____

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Medical History Continued

Please answer the following questions and provide details to any "yes" answers.

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:

1. Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heartbeat, or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No
2. Diabetes or thyroid disease? ☐ Yes ☐ No
3. Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis, or any other disorder of the brain or nervous system? ☐ Yes ☐ No
4. Arthritis, gout, or any bone, joint, muscle, or skin disorder? ☐ Yes ☐ No
5. Asthma, bronchitis, pneumonia, emphysema, or any lung disorder? ☐ Yes ☐ No
6. Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach, or intestines? ☐ Yes ☐ No
7. Prostate or testicular disease, disease of the uterus, ovaries, or breast? ☐ Yes ☐ No
8. Anemia, leukemia, clotting disorders, or platelet disorders? ☐ Yes ☐ No
9. Disorder of the urinary tract or kidneys—sugar, albumin, or blood in the urine? ☐ Yes ☐ No
10. Cancer or tumors? ☐ Yes ☐ No
11. Sleep apnea? ☐ Yes ☐ No
    Severity (if known)_____ CPAP or treatment use? ☐ Yes ☐ No
12. An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV), or diagnostic tests (including treadmill stress test for insurance?) ☐ Yes ☐ No
13. Any other health impairment or medically treated condition not previously mentioned? ☐ Yes ☐ No
14. Within the last 10 years, have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

*Additional medical and non-medical forms are available in the Find Forms section on **www.highlandbrokerage.com.***

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS in the space below. Attach additional pages if necessary. Please be specific with this information to expedite the process.

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Requested Coverage

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship ☐ Variable

Face amount desired $_____ What will be the purpose of the insurance?_____

Have you ever been declined or rated when applying for life insurance? ☐ Yes ☐ No

If yes, when and why?_____

Existing Insurance

Do you currently have active insurance coverage? Will this coverage be replaced?

Company	Type	Amount	Replacing?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Agent Information

Name: _____ Firm: _____

Phone number: _____

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Authorization to Obtain and Disclose Confidential Information

This form is HIPAA Compliant

Proposed Insured's Name: _____

Date of Birth: _____ SSN: _____

Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Highland Capital Brokerage, Inc., HCB Insurance Services, Inc. (in California), brokers, contractors, employees, representatives and agents working for or through Highland Capital Brokerage for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurers & Agencies

Accordia Life
Allianz Life Insurance Co. of North America
American General Life Insurance Co.
American National Insurance Co.
American National Insurance Co. of NY
Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of NY
Ashar Group, LLC
Assurity Life
AXA Equitable Life Insurance Co.
Banner Life
Brighthouse Financial
Companion Life Ins. Co.
Coventry First, LLC
Evergreen Settlements, LLC
Fidelity Life Association
Fidelity Security
First Symetra National Life Ins. Co. of NY
Focus 10 Life, Inc.
Gerber Life Insurance Co.
Highland Capital Brokerage, Inc.
Illinois Mutual
John Hancock Life Insurance Co. (U.S.A.)
John Hancock Life Insurance Co. of NY
Lighthouse Life
Lincoln National Life Insurance Co.
Lincoln Life & Annuity Co. of NY
Life Insurance Settlements, Inc.
Lloyds of London
Manufacturers Life Insurance Co. (Bermuda)
Massachusetts Mutual Life Insurance Co.
Met Life DI
Minnesota Life
Mutual of Omaha
National Life Group
National Western Life Insurance Co.
Nationwide Life & Annuity Co.
New York Life Insurance & Annuity Co.
New York Life Insurance Co.
North American Co. for Life and Health Insurance
NYLIFE Insurance Co. of AZ
OneAmerica
Pacific Life Insurance Co.

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Insurers & Agencies continued

This form is HIPAA Compliant

Pacific Life & Annuity Co.
Pan-American Life Insurance Group
Pan-American International Insurance Corp.
Petersen International
Principal Life Insurance Co.
Principal National Life Insurance Co.
ProFinancial Services
Protective Life Insurance Co.
Protective Life & Annuity Insurance Co.
Pruco Life Insurance Co.
Pruco Life Insurance Co. of NJ
Prudential Insurance Co. of America
RISK (Fidelity Security)
Securian Life Insurance Co.
Securities America, Inc
Standard Insurance Co.
State Life Insurance Co.
Symetra Life Insurance Co.
The Independent Order of Foresters
Transamerica Life (Bermuda) Ltd.
Transamerica Life Insurance Co.
Transamerica Life Insurance & Annuity Co.
Transamerica Financial Life Insurance Co.
United of Omaha
United States Life Insurance Co.
Unum
USG Annuity & Life
William Penn Life Insurance Co. of NY
Zurich American Life Insurance Co.
Zurich American Life Insurance Co. of NY

Additional Insurers & Agencies

_____

_____

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, (15) other personal traits, (16) pharmacy and (17) pharmacy benefit managers.

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I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

With this signed Authorization to Obtain and Disclose Confidential Information, I specifically authorize any medical practitioner, any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer to release and disclose the protected health information (PHI) described above to the following authorized recipient of the PHI, for the purpose described above:

☐ Express Imaging Services, Inc., 1805 W. 208th St., Ste. 202, Torrance, CA 90501

OR

☐ Other: _____

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed afore may use the secured internet-based system called "PaperClip, Inc." 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 federal and state laws and regulations that may have applied in the first instance. This Authorization will expire 24 months after the date of my signature below. My initials specifically authorize the release of my information related to any future treatment I may

receive after the date of my signature on this Authorization as long as such treatment occurs prior to the expiration of this Authorization. _____
(initial here)

I understand I may revoke this Authorization at any time by requesting such of my agent/ broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

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). If minor children are proposed for coverage, the above statements are made by the 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) _____
(city, state)

Signature of Proposed Insured or Individual's Legally Authorized Representative:

_____

Complete if Signed by Legally Authorized Representative:

Printed Name of Authorized Representative: _____

Relationship to Individual: _____

Signature of Witness: _____

Signature of Policy Owner(s): _____
(not required)

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child:_____

Relationship of Representative to Minor: _____

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NOTICE TO PROPOSED INSURED

Instructions to Producer: This notice 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.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

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At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

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. This also authorizes 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 REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.

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