

**Insurance Solutions Group, Inc.**

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**PRELIMINARY UNDERWRITING INQUIRY FORM**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

ADDRESS: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

HOME TELEPHONE: \_\_\_\_\_ WORK TELEPHONE: \_\_\_\_\_

TOBACCO USER? \_\_\_\_ CIGARETTE SMOKER? \_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

CASE SUMMARY (include pertinent medical history, current medications, or any other considerations, including full name and address of physicians and hospitals consulted in the past:

Physicians/Hospital Consulted: \_\_\_\_\_ Reason: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Physicians/Hospital Consulted: \_\_\_\_\_ Reason: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, sanitarium or other medically related facility, insurance company and their reinsurers, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give **Insurance Solutions Group, Inc.** any such information for the express purpose of submitting records to any life insurance company or companies which **Insurance Solutions Group, Inc.** represents. **A Photostatted copy of this authorization shall be as valid as the original.** Some companies **Insurance Solutions Group, Inc.** represents are:

- |                         |                    |               |                      |
|-------------------------|--------------------|---------------|----------------------|
| First Penn Pacific Life | Lincoln Benefit    | ING/Reliastar | Lincoln Life         |
| Empire General          | American General   | New York Life | State Life           |
| Prudential Life         | Manulife Financial | Mass Mutual   | Guarantee Trust Life |
| U.S. Financial          | United of Omaha    | Banner Life   | Sun Life             |

**I HAVE RECEIVED THE NOTICE OF EXCHANGE OF INFORMATION AND FAIR CREDIT ACT**

Date: \_\_\_\_\_

Witness: \_\_\_\_\_  \_\_\_\_\_

**Applicant must read above statement before signing**

**NOTICE TO PRELIMINARY UNDERWRITING APPLICANT**

Information regarding your insurability will be treated as confidential. The insurance companies listed and their reinsurers on this form 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 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 in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Medical information will be disclosed only to your attending physician. 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 Post Office Box 105, Essex Station, Boston, Massachusetts, 02112. Telephone number is (617) 426-3660.

The insurance companies listed and their reinsurers on this form 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.