American Financial Network, LLC
14 Walsh Dr., Suite 201, Parsippany, NJ 07054
Tel 973-263-0054 Fax 973-263-0043

INFORMAL INQUIRY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (last, first, M.I.)	Telephone:	DOB:	Height:	Weight:
Address:	City, State, ZIP			
Primary Doctor:	Telephone:	Date of last visit:		
Address:	City, State, ZIP			
List of Specialists:				
Doctor's Name:	Specialty	Telephone:		
Doctor's Name:	Specialty	Telephone:		

PERSONAL HEALTH HISTORY

Please check the boxes below for all those that apply	**Details of Yes Answers** **Include give dates, diagnosis, details and treatment. Be sure to include names and addresses of all attending physicians and medical facilities**

1.Have ever been treated for or had any indication of:

☐a. Disorder of the eyes, ears, nose or throat?

☐b. Dizziness, fainting, convulsions, headache, speech defect, Paralysis, or stroke, mental or nervous disorder?

☐c. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder?

☐d. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?

☐e. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder?

☐f. Sugar, albumin, blood or pus in the urine, venereal disease, nephritis, stone, and or disorder of the kidney, bladder, prostrate or reproductive organs?

☐g. Diabetes, thyroid, or other endocrine disorder?

☐h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones?

☐i. Deformity, lameness, or amputation?

☐j. Disorder of skin, lymph glands, cyst, tumor, or cancer? k. Allergies, anemia, or other disorder of the blood?

2. In the past 10 years have you:

☐a. Had or been told you have or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC) or AIDS related conditions?

☐b. Tested positive for antibodies to AIDS (Human T Cell Lymphotrophic, Type III;HTLV-III) virus?

3. Have you ever:

☐a. Used or currently use barbiturates, amphetamines, hallucinogenic drugs (including Marijuana), narcotics, or any prescription drug except in accordance with a physician's instruction?

☐b. Received counseling advice or treatment regarding the use of alcohol or drugs?

4. Are you currently receiving any medical treatment? ☐Yes ☐ No

5. Other then in any items already listed, have you, within the past 5 years, been a patient in a clinic, sanitarium, or hospital? ☐Yes ☐No

6. Have you ever used tobacco products? ☐Yes ☐No
If you quit, when did you quit?

7. Have used any tobacco products in the past 12 months? ☐Yes ☐No

8. Do you currently use a nicotine patch or other nicotine product to help stop smoking? ☐Yes ☐No

Personal Health History Continued

HEART

Have you had any of the following:

☐ High Blood Pressure?	Last BP reading?		
☐ High Cholesterol:	Total Chol. Level:	Ratio:	
☐ History of Chest Pain?	Evaluated?	Diagnosis?	
☐ Heart Attack?	# of attacks	Dates:	
Any resulting impairments:			
☐ By-Pass Surgery?	# of vessels:	name of vessels:	Date:
☐ Coronary Angioplasty?	# of vessels:	name of vessels:	Date:
☐ Stent?	Which vessels:		
☐ Heart Failure?	# of times:	Congestive?	
☐ Valve Surgery?	Name of Valve:	Date:	
☐ Pacemaker?	Type:	Date:	
☐ Atrial Fibrillation?	☐ Chronic	☐ Single Episode	
☐ Premature Ventricular Beats (PVC's)	☐ Premature Supraventricular Atrial Beats (PAC's)		
Date of last electrocardiogram:	☐ Abnormal	☐ Normal	Attending Physician?

Were any of these tests completed:

☐ Stress Electrocardiogram?	Date:	☐ Abnormal	☐ Normal	Attending Physician
☐ Echocardiogram?	Date:	Was it done while exercising?		
☐ Thallium Stress EKG?	Date:	Attending Physician?		
☐ Coronary Angiogram?	Date:	# of diseased vessels	Attending Physician?	

CANCER

Location of Cancer:	Diagnosis Date:	
Exact Name of Cancer:		
Who would have the Pathology report?	Number of adjacent Lymph Nodes with abnormal cells:	
Any Radiation or Chemotherapy?	Date of Last Treatment:	
Has there been any reoccurrence of cancer?		
IF skin cancer, was it melanoma	Clarks or Breslows Thickness rating:	
IF prostate cancer	Gleason Score:	Staging:
PSA at diagnosis:	Current PSA:	Treatment:

DIABETES

Date of Diagnosis:	Treatment:	Name of medication:
Weight 1 yr ago:	Weight now:	Height:
How often are sugar levels monitored?		
Date of last test:	Results:	
Last Hemoglobin A1C reading:	Date:	
Last MicroAlbumin leve:	Date:	
Last Glucose level:	Date:	
Any complications? (e.g. eyes, heart, kidney, etc)		
Details:		

Family History

	Age if living	Age at death	History of Cardiovascular Disease	Age of onset	History of Cancer	Age of onset
Father						
Mother						
Siblings						

AUTHORIZATION TO RELEASE INFORMATION

American Financial Network LLC or any of the other entities listed below, or their subsidiaries or reinsurers or authorized representatives, any and all such information. I UNDERSTAND that under Federal Regulations I may revoke this authorization as it applies to drug and alcohol abuse treatment at any time; but said revocation will not affect any information that may have been released prior thereto.
I UNDERSTAND that the information obtained by use of this authorization will be used by American Financial Network LLC and the entities listed below, and their subsidiaries and reinsurers, to determine insurability. American Financial Network LLC and the entities listed below, and their subsidiaries and reinsurers, may also release information in their file to other companies to which I may apply for life or health insurance.
I UNDERSTAND that I may request a copy of this form.
I AGREE that a photocopy of this form will be as valid as the original.
This AUTHORIZATION will be valid for 2 years from the date shown below.

American General Life Ins Co
Allianz Insurance Group
American General Life Insurance Company
American Life and Annuity Ins. Co.
American National Insurance Company
Athene Annuity & Life Assurance Company
Assurity Life Insurance Company
AXA Financial
Banner Life Insurance Company
Brighthouse Life Insurance Company
Columbian Financial Group
Companion Life Ins Co
Empire General Life Assurance Corp
Equitrust Life
Exceptional Risk Advisors, LLC
Fidelity and Guaranty Life Ins. Co.
Fidelity and Guaranty life ins. Co. of NY
Foresters Life Ins & Ann
Fort Dearborn Life
Gerber Life Ins Co
Genworth Life Insurance Company

Global Atlantic Financial Group
Guggenheim Life and Annuity Company
The Guardian Life Insurance Company of America
John Hancock Life Insurance Company
Lafayette Life Insurance Company
Legacy Planning Partners, LLC
Lincoln Financial Group
Lloyd's of London
Massachusetts Mutual Life Insurance Company
Metropolitan Life Insurance Company
Mutual of Omaha
Minnesota Life
National Western Life
National Life Group
Nationwide
New York Life Insurance Company
North American Life
Old Mutual Life
OneAmerica

Pacific Life Insurance Company
Penn Mutual Life Insurance Company
Principal Life Insurance Company
Principal National life Insurance Company
Protective Life and Accident Insurance
Prudential Insurance Co.
Pruco Life Insurance Co. of America
Reliastar Life Insurance Co.
Reliastar Life Insurance Co. of NY
Savings Bank Life Ins Co of MA
Security Life of Denver Insurance Co.
Security Mutual Life Ins Co of NY
StanCorp Financial Group, Inc.
Symetra Life Insurance Company
Transamerica Insurance & Investment Group
United Home Life Ins Co
Unum Life Insurance Company
William Penn Life Ins Co of NY
Western Reserve Life
Welcome Funds
Zurich American Life Insurance Company

NOTICE TO PROPOSED INSURED

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is attained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. The inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. If a report is made, you may request the name, address and telephone number of the consumer reporting agency from whom you may request a copy of the report.
Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of it's members. If you apply to another Bureau member company for life or health insurance coverage or a claim of benefits is submitted to such company, the bureau, upon request, will supply such company with the information it may have in its file.
Upon receipt of the request from you, the bureau will arrange disclosure of any information it may have in your file. NOTE: (medical information will be disclosed only to your attending physician) If you question the accuracy of the 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, Tel. (617)426-3660.
The companies listed in this notice or their reinsurers may also release information in their files 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.

CLIENT NAME PRINTED:	**Social Security#:**	**DOB:**
CLIENT SIGNATURE:		**DATE:**
CLIENT NAME PRINTED:	**Social Security#:**	**DOB:**
CLIENT SIGNATURE:		**DATE:**