INFORMAL APPLICATION

SIMPLICITY GROUP

Date: **Authorization Form**

Personal History (required)

Name:	Sex: M F	Soc. Sec. #:	
Address:	City:	State:	Zip:
Telephone:	Date of Birth:	Height:	Weight:
Occupation:	Monthly Earned Income:	Net Worth:	
DL#:	State:	Email:	

Tobacco / Nicotine Usage (required)

1. Have you ever smoked cigarettes? Yes No If yes, date of last usage:
2. Have you ever used other tobacco or nicotine products? Yes No

   If yes, provide types and last date of use:

Agent Information (required)

Name:	Soc. Sec. #:		
Address:	City:	State:	Zip:
Telephone:	Fax:		
E-mail:			

Requested Plan of Insurance

Universal Life Variable Life Whole Life Term, Level Period Survivorship

Face amount desired:	Max. premium commitment:
1035 exchange or dump in? How much?	
What is the primary purpose of this insurance policy? **Please have other proposed insured submit Informal App as well.*	

Provide details on pending and in-force coverage:

Please provide details.

Company	Policy/App Date	Amount	Class/Rating Issued	Current Premium	Replacing?
					Yes No
					Yes No
					Yes No
					Yes No

INFORMAL APPLICATION

SIMPLICITY GROUP

Proposed Insured: **Date of Birth:**

Medical History (required)

Who is your primary care physician? Address Telephone	Date of Last Consultation	Reason/Illness
What other physicians have you consulted with in the last 5 years? (Do not include insurance examinations) Address Telephone		
In which hospitals, clinics, or other health facilities have you been treated (If Applicable)?		

Please list all current medications: Name	Dosage	Frequency	Reason for taking

Drug and Alcohol (required)

Do you currently drink alcohol? Yes No

Date of last consumption:

Note amount below:

Type	Amount per week

Did you ever drink more than you currently do? Yes No

If yes, when?

Note amount below:

Type	Amount per week

Have you ever consulted a doctor or received a treatment because of your alcohol use? Yes No

Have you ever been arrested for driving under the influence of alcohol? Yes No

If yes, please provide date(s):

Have you ever sought medical treatment because of drug use, or has drug use ever been a problem? Yes No

If yes, please provide details:

Types of drug(s) used:

Date of last use:

Proposed Insured: **Date of Birth:**

Coronary (check here if this section is not applicable)

1. Date of diagnosis or first chest pain:
2. Number of diseased vessels:
3. Dates/details of treatment/surgery (i.e., Angioplasty, Bypass, etc.):
4. Date of last stress EKG:
   Results:
   By whom:
5. Any pain since treatment/surgery?

Cancer (check here if this section is not applicable)

1. Exact name and location of cancer:
2. Stage and grade:
3. Who has the pathology report?
4. Dates/details of treatment/surgery:

Diabetes (check here if this section is not applicable)

1. Date of diagnosis:
2. Treatment: (mark one) Diet Only Oral Medication Insulin
   Details:
3. Do you regularly test your blood glucose? Yes No
   Results: Frequency:
4. Have you ever been diagnosed with having protein and/or microalbumin in your urine? Yes No
5. Have you ever had:
   a. Eye trouble? Yes No
   b. Heart trouble? Yes No
   c. High blood pressure? Yes No
   d. Kidney trouble? Yes No
   e. Neuritis/neuralgia? Yes No
   f. Insulin reactions? Yes No

Other Health Details:

Proposed Insured: **Date of Birth:**

Medical Check-ups

Procedures	Date of last test	Check-ups often?	Results normal?	If particularly good, any reason why? (i.e., diet)
Blood Pressure check-up			Yes No	
Cholesterol screen			Yes No	
Electrocardiogram (EKG) resting			Yes No	
Electrocardiogram (EKG) stress			Yes No	
Chest x-ray			Yes No	
Sigmoidoscopy			Yes No	
Mammogram (women)			Yes No	
Prostate exam (men)			Yes No	
Other			Yes No	

Nutritional Supplements

Name of supplement	Dates used	Quantity taken	Frequency taken
Multi-vitamin / Mineral supplements			
Special dosage of Vitamin E			
Special dosage of Folic Acid			
Aspirin: Regular Baby			
Other			

Lifestyle Variables

Describe your exercise program	
List sports you engage in regularly	
Describe your alcohol / tobacco usage	
Do you work full time?	
Other favorable lifestyle habits	

Proposed Insured: **Date of Birth:**

Family History (required)					
	Age	Age of death	Cause of death if deceased	History of heart disease or circulatory disorder	History of cancer (all types)
Mother				Yes No	Yes No
Father				Yes No	Yes No
Sister(s)				Yes No	Yes No
Brother(s)				Yes No	Yes No

DOCTOR INFORMATION

Your life insurance application must be accompanied by copies of your doctor's records (*this includes records from your primary care physician along with any specialists or other doctors you may have seen in the last 10 years). Please fill out the following information and be as detailed as possible. Incomplete information can cause significant delays and could result in a lengthy processing time. Attach pages as needed.

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

You may want to alert your doctor(s) that you are applying for life insurance and that they may receive a request for an APS (Attending Physician Statement). This allows them to begin preparing the paperwork.

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize my Representative and any affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefit manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") concerning me to my Representative and its staff, affiliated companies and/or entities, including but not limited to insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, my prescription records and history of medications prescribed, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements that I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to my Representative and any affiliated agencies. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation may not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, my Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured Name	Proposed Insured Signature
Signed and Dated On	Location Signed
Representative Name	Representative Signature

Accordia, American General Life Ins Co, Allianz Insurance Group , American Life and Annuity Insurance Company, American General Life Insurance Company, American National Insurance Companies, America United Life, Assurity Life Insurance Company, Athene Annuity & Life Assurance Company, AXA Financial, Banner Life Insurance Company, Brighthouse Life Insurance Company, Columbian Financial Group, Companion Life Insurance Company, The Coventry Group, Credit Suisse Group, Empire General Life Assurance Corp, EP Insurance Services, Equitrust Life Exceptional Risk Advisors LLC , Fidelity and Guaranty Life Ins Co, Fidelity and Guaranty Life Ins Co of NY, Foresters Life Insurance & Annuity, Fort Dearborn Life, Gerber Life Ins Co, Global Atlantic Financial Group, Guggenheim Life and Annuity Company, The Guardian Life Insurance Company of America, Genworth Financial Family of Companies, AVIVA & Affiliates, A.I. Credit Corp., HSBC, ING USA Annuity and Life Insurance Company, John Hancock Life Insurance Company, Lafayette Life Insurance Company, Legacy Planning Partners, Liberty Life Insurance Company, Lifestyle Settlements, Lincoln National Life Insurance Company and their affiliates, Lloyd's of London Massachusetts, Minnesota Life, Mutual Life Insurance Company, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Mutual Trust Life, Nationwide Life Insurance Company, National Western Life National Life Group, Nationwide Life and Annuity Insurance Company, New York Life Insurance Company, North American Company for Life and Health Insurance, Old Mutual Financial Life Insurance Company, One America, Pacific Life Insurance, Peachtree Settlement Funding, Penn Mutual Life Insurance Company, Perry Financial, Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life and Accident Insurance, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, State Life, ReliaStar Life Insurance Company of New York, Savings Bank Life Insurance-SBLI, Security Life of Denver Insurance Company, Security Mutual Life Ins Co of NY, StanCorp Financial Group, Inc, Superior Mobile Medics, Symetra Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United Home Life Ins Co, United States Life Insurance Company in the City of New York, Unum Life Insurance Company, William Penn Life Insurance Company of New York, West Coast Life Insurance Company, Western Reserve Life, Welcome Funds, Zurich American Life Insurance Company