The Insurance Group tig

INFORMAL INQUIRY

Instructions

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages. If additional space is needed, add a separate page. Complete, accurate information produces the most competitive carrier offers. Because of the significant expense involved in purchasing medical records. TIG's underwriting staff has final discretion regarding pre-purchase of client's medical records.

If submitting your informal Survivorship quotes, please complete a separate application for each proposed insured and submit together.

1. Broker/Advisor Information

Name ____________________ Firm/Agency ____________________

Phone ____________ Fax ____________ Email ____________________

2. Case Design Information

Check one: ☐ Single Life Case ☐ Survivorship (complete 2 apps)

Check one: ☐ Universal Life ☐ Indexed Universal Life ☐ Whole Life ☐ Term (Period____) ☐ ROP Term ☐ Survivorship (UL or IUL) ☐ Other________

Death Benefit Amount ____________________ If no lapse, carry guarantee to age____________________

Riders ____________________

Premium design (i.e. lump sum, 1035, limited pay) ____________________

Purpose of coverage (i.e. estate plan, buy-sell, etc) ____________________

____

3. Proposed Insured Information

Proposed Insured Full Name ____________________ Daytime Phone____________________

Social Security Number ______-_____-______ Date of Birth (mm/dd/yyyy) _____/_____/_______

Residence Address ____________________

City ____________ State ____________ Zip code ________

(Check One)
☐ Male
☐ Female

Present Nicotine Use:

☐ None ☐ Cigarettes-- frequency of use per day: ______________

☐ Cigars ☐ Pipe ☐ Dip ☐ Chew ☐ Nicotine Gum ☐ Other: ______________

Quantity per month ______________

Former Tobacco Use: List each type of tobacco, quantity and frequency used, and date of last use:____________________

____

Build: Height ____ feet ____ inches Weight _____ pounds_Has there been any weight change during last 12 months? ☐ No ☐ Yes

If Yes, provide details ____________________

Family History (Family history is a consideration for each rate class):

To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60 due to cardiovascular disease, cerebrovascular disease, diabetes, or cancer? ☐ Yes ☐ No

If yes, provide full details of impairment, age at onset and age of death if deceased:

☐ Father: ____________________

☐ Mother: ____________________

☐ Siblings: ____________________

The Insurance Group © 2014

Aviation/Avocation:

In the past 5 years have you or do you intend to participate in any of the activities listed?

☐ None ☐ Flying ☐ Racing ☐ Sky diving ☐ Scuba diving ☐ Other

Citizenship/Residency/Travel:

US Citizen: ☐ Yes ☐ No If no, provide type and expiration date of visa, green card status, and length of time in USA: ______________________________

Any future plans to live or travel outside the USA?: ☐ Yes ☐ No If yes, provide purpose, cities, countries, frequency, and duration: ____________________

Driving History:

Have you had any of the following motor-vehicle-related incidents in the past 10 years?

☐ Moving violation ☐ Reckless driving ☐ DWI or DUI ☐ License suspension ☐ License revoked

Provide dates, details: ______________________________

Medical History:

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply:

- ☐ Alcohol Abuse
- ☐ Alzheimer's/dementia/cognitive impairment
- ☐ Asthma
- ☐ Cancer
- ☐ Cirrhosis
- ☐ COPD
- ☐ Coronary artery or cerebrovascular disease
- ☐ Crohn's disease
- ☐ Depression/anxiety
- ☐ Diabetes
- ☐ Drug abuse
- ☐ Epilepsy
- ☐ Heart murmur/valve disease
- ☐ Hepatitis
- ☐ Irregular heartbeat/palpitations
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Multiple sclerosis
- ☐ Peripheral vascular disease
- ☐ Rheumatoid arthritis
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Other

List dates, diagnosis, details treatment, plus names, addresses, and phone numbers of all physicians consulted (Refer to Common Medical and Non-Medical Impairment sections for critical underwriting factors):

List all medications, dosage and/or frequency, the reason being taken, name of prescribing physician:

The Insurance Group © 2014

Physician(s) Information:

Primary Insured Info		
Physician's Name	Specialty	Phone
1)		
Address	City	State: Zip:
2)		
Address	City	State: Zip:
3)		
Address	City	State: Zip:
4)		
Address	City	State: Zip:
5)		
Address	City	State: Zip:
6)		
Address	City	State: Zip:

Last Doctor Visit: _____/_____/_____ Reason/Treatment: ________________________________

Last Hospital Stay: _____/_____/_____ Reason/Treatment: ________________________________

Surgeries recommended but not performed: ________________________________

Offers by other companies:

Company: ____________________ Date: ____________ Amount: $ ____________

____

Action (s): ________________________________

________________________________ Premium Amount Desired: $ ____________

Are you currently being considered by another agency? ☐ Yes ☐ No If yes, what agency: ____________________

Have you been declined, rated, or postponed for coverage with any carrier? ☐ Yes ☐ No

If yes, what carrier? ____________________ When: _____/_____/_____ Why? ____________

The Insurance Group © 2014