Equity Brokerage

Date:

Authorization Form

Personal History (required information)

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

Tobacco / Nicotine Usage

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 (required)

☐ Universal Life ☐ Variable Life ☐ Whole Life ☐ Term, Level Period ☐ Survivorship

Face amount desired:	Max. premium commitment:

1035 exchange or dump in? How much?

What will be the purpose of insurance?
**Please have other proposed insured submit Informal App as well.*

Provide details on pending and in-force coverage:

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

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Toll-Free 888-763-9701 / Local 704-375-0555
1230 W. Morehead Street, Suite 207 / Charlotte, NC 28208 / www.equitybrokerage.com

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Proposed Insured: **Soc. Sec. #:**

Medical History (required information)

Who is your primary care physician? Doctor's name, address, phone #. When did you last consult her/him?	Date	Illness
What other physicians have you consulted within the last 5 years? (Do not include insurance examinations)		
In what hospitals, clinics or other health facilities have you been treated?		

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

Drug and Alcohol Questionnaire (required)

Do you currently drink alcohol? ☐ Yes ☐ No
Date of last consumption:
Note amount below:

Did you ever drink substantially more than present? ☐ Yes ☐ No
If yes, when?
Note amount below:

Type	Amount per week	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:

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Proposed Insured: **Soc. Sec. #:**

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 would have 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. Any 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:

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Proposed Insured: **Soc. Sec. #:**

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	
Sports you engage in regularly	
Describe your alcohol / tobacco usage	
Are you actively at work full time?	
Other favorable lifestyle habits	

Family History					
	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

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REQUIRED – DOCTOR INFORMATION

Along with your life insurance application, the company you are applying with requires us to order copies of your doctor's records. This includes your primary care physician along with any specialists or other doctor's you may have seen. Please be as detailed as possible as to the name, address and phone number of your doctors. Incomplete information can cause significant delays and will result in a lengthy processing time.

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 call your doctor to give them a head's up that you are applying for life insurance and that we will be requesting an APS (Attending Physician Statement) from them. This may give some time for them to prepare your paperwork and have it ready.

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Equity Brokerage, Inc. (the "Representative") and its affiliated agencies, including but not limited to RSA, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

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 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements 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 the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure 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 at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

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 the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the 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 refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured's Name	Proposed Insured's Signature	Proposed Insured Date of Birth
Signed and Dated On	**At (City, State, Zip Code)**	**At (City, State, Zip Code)**

Agent/Witness Signature: _____ **Print Agent/Witness Name:** _____

Accordia Life, AIG, American General Life Insurance Company, American National Insurance Companies, American United Life Ins. Co., AXA Equitable Life Insurance Company, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, General Re Life Corp, VOYA Financial, Inc. John Hancock, Lincoln National Life, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Minnesota Life, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, North American Co. for Life and Health, OneAmerica, Pioneer Mutual Life Ins. Co., Principal Life Insurance Co., Principal National Life Insurance Co., Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Savings Bank Life Ins. Co., Security Life of Denver Insurance Company, The State Life Ins. Co., Symetra, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, West Coast Life Insurance Company.