# KAFL
INSURANCE RESOURCES

# Informal Inquiry: Preliminary Application

*Detach and give to proposed insured*

Date:______________________

Client's Name:______________________

Agent's Name:______________________

Agent's Telephone:______________________

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INSURANCE RESOURCES


# Informal Inquiry: Preliminary Application


| Full Name: | | Plan of Insurance: | Amount Desired: |
|---|---|---|---|
| Date of Birth: | Place of Birth: | Social Security #: | Agent Remarks: |
| Resident Address: | | Beneficiary (name and relationship): | |

○ Male ○ Female ○ Single ○ Widowed ○ Married ○ Divorced

Occupation:

Employer:

Address:

For how much are you now insured?:

| Company | Amount | Year |
|---|---|---|
| | | |

| Have you ever been ○ Declined? ○ Rated? Provide details | Name of Company | Year | Give reason/table rating or extra premium per thousand: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | Name and Address | Reason | Date |
|---|---|---|---|
| What physician did you last consult? *(Other than insurance examination)* | | | |
| What physicians have you consulted during the past ten (10) years? | | | |
| In what hospitals, clinics, or sanitariums have you ever been treated? | | | |
| Who is your personal physician? When did you last consult him/her? | | | |

| Height *(in shoes)* ____ *feet* ____ *inches* | Weight *(in shoes)* ____ *pounds* | What medical impairments do you now have? *(Please complete supplemental questions)* |
|---|---|---|

**Submitting Agent:** ***Email address:***

Name:______________________

Address:______________________

Phone:(      )______________ Fax:(      )______________

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○ **Exclusive:** *This case is not being shopped other than my own company.*
○ **Shopped:** *This case is out to other sources by me.*
○ **Shopped:** *This case is out to other sources by another agent.*

| YES | NO | **Do you now, or have you ever, used tobacco in any form?** |
|---|---|---|
| ○ | | If YES:<br>t1) What do you use?<br>t2) How often? |
| | ○ | If NO:<br>t3) When did you stop? |
| ○ | ○ | t4) Did you stop on the advice of a physician *(If yes, explain and give name and address)* |

**NOTICE TO PROPOSED INSURED:** Federal law requires that you be advised that in connection with this informal inquiry, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the Company within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested and if such a report was requested you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of the investigation. You have the right to inspect and to receive a copy of such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The insurance companies listed on this Informal Inquiry or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life companies, which operates an information exchange bureau 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 it may have in its file.

Upon 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 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 02110. Telephone: 617-426-3660.

Any cf the listed companies or their reinsurers may also release information in its file to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

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The terms that follow have these respective meanings when used in this Authorization:

AUTHORIZATION: Authorization to Obtain and Disclose Information
INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU: Medical Information Bureau, Inc.

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

**Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organization; (7) financial source; and (8) employer, to give the types of information listed below when this Authorization is presented. A copy of this Authorization is as valid as the original. I authorize all said sources, except the Bureau, to give such records of knowledge to KAFL, Inc.**

**The types of information will include facts about my (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits.**

The life insurance companies named below and their reinsurers will use the information in order to determine whether I am insurable. The insurance agent may also use this information to help update and improve my insurance program.

Those parties named in the first paragraph may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; or (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be otherwise allowed by law.

This Authorization will be valid for two years after the date signed. I understand that I or my authorized representative may ask to be given a copy of this Authorization. I acknowledge receipt of the Notice of Information Practices and the Notice to Proposed Insured.

Signed at ______________________ this ________ day of ____________________ , 20 ______ .

Proposed Insured
or Other Authorized Person: ______________________________________________

Witness: ______________________________________________

# SUPPLEMENTAL IMPAIRMENT QUESTIONS

| Full Name: | Date of first diagnosis of<br>Chest Pain Diabetes Cancer |
|---|---|
| Name and Address of physician first consulted: | City, State, Zip |

## CORONARY

YES NO **Have you ever had or been treated for:**

- O O a1) Chest pain?
- O O a2) Skipping of heart?
- O O a3) Shortness of breath?

**Pain was located in:**

- O O a4) Middle of chest?
- O O a5) Left side of chest?
- O O a6) Left shoulder or arm?
- O O a7) Both shoulders or arms?
- O O a8) Stomach?

**Pain was brought on by:**

- O O a9) Exertion?
- O O a10) Exercise?
- O O a11) Excitement?
- O O a12) Strain?

**Did you have:**

- O O a13) Pressure or constriction?
- O O a14) Sweating?
- O O a15) Hospital care required?
- O O a16) More than one episode?
- O O a17) Heart attack diagnosed?
- O O a18) Are you, or have you been on, medication such as digitalis, peritrate, nitroglycerine, vasodialators, blood pressure medication, or similar medications?
- O O a19) Have you had a treadmill electrocardiogram or an angiogram?
- O O a20) Have you had angioplasty or bypass surgery?

## ALCOHOL & DRUGS

YES NO

- O O c1) Do you consume alcohol or drugs at the present time?
- O O c2) Are you involved in AA or any other substance support group?
- O O c3) Ever been arrested or convicted for any alcohol or drug violation?
- O O c4) Have you ever had alcohol or drug treatment or counseling?

c5) Date of last use:

c6) List all doctors, hospitals & medical facilities who have or now treat you:

## DIABETES

YES NO **What treatment do you use for your diabetes:**

- O O b1) Diet only?
- O O b2) Oral tablets?
- O O b3) Insulin injection?
  - Type:
  - Daily dose:

**What type of self-testing do you perform:**

- O O b4) Blood?
- O O b5) Urine?

**Results:**

- O O b6) Usually negative?
- O O b7) Usually a trace?
- O O b8) More than a trace?
  - Frequency:
  - Last result:
  - Average result:
- O O b9) Have you had Hemoglobin A1C tested?
  - Date: Result:

**Have you been treated for:**

- O O b10) Insulin reactions?
- O O b11) Diabetic coma?
- O O b12) Eye trouble?
- O O b13) Heart trouble?
- O O b14) High blood pressure?
- O O b15) Kidney trouble *(albumin)*?
- O O b16) Neuritis or neuralgia?
- O O b17) Arteriosclerosis?
- O O b18) Liver disorders?
- O O b19) Skin problems *(infections)*?
- O O b20) Big weight changes?
  - Weight 1 year ago:

## FINANCIAL

YES NO

What is purpose of insurance?

Who is the policy owner?

Relationship to insured?

- O O d1) Are other owners, partners or officers being covered?

Applicant net worth:

Business net worth:

Annual income of applicant:

Describe any recent bankruptcy:

## CANCER

**Type(s) of cancer:**
*(give full medical name, if known)*

Stage, level or grade:

Location of cancer:

Type(s) of treatment given:

Date treatment started:

Most recent treatment:

Date of last follow-up:

## OCCUPATION & OTHER

YES NO **Describe occupation with special attention to hazards:**

**Driving:**

- O O e1) Is license valid now?
  - Number of convictions in the past five (5) years:
- O O e2) Any D.W.I.?

**Criminal:**

When convicted:

Offense:

- O O e3) Currently on probation?

e4) Other details:

**Aviation:**

Total solo hours:

Solo hours last year:

Anticipated next year:

- O O e4) Any crop dusting, stunt flying, over water flying or experimental craft?

Class of License:

**Racing:**

What class?

Highest speed:

Frequency:

Type of vehicle:

**Diving:**

Frequency:

Maximum depth:

Diving organization:

*Agent*

KAFL, Inc.
800 Linden Avenue
Rochester, NY 14625

**Informal Inquiry:**
**Preliminary Application**

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INSURANCE RESOURCES

KAFL Insurance Resources
800 Linden Avenue, Rochester, NY 14625
Phone (585) 271-6400 ~ Fax (585) 271-5050 ~ (800) 272-6488

***Details to all yes answers, with dates:*** ______________________________

______________________________

______________________________

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______________________________

The statements and answers shown above are complete and true to the best of my knowledge and belief.

Signature of Proposed Insured ______________________________ Date ____________, 20 ___

## Authorization for Release of Health-Related Information to KAFL, Inc.

**This authorization complies with the HIPAA Privacy Rule**

____________________________________________________________ ___/___/___

Name of proposed insured/patient (please print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to KAFL, Inc ("the Company") and its agents, employees, and representatives. 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 800 Linden Avenue, Rochester, NY 14625. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization, the Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

____________________________________________________________________

Signature of Proposed Insured/Patient or Personal Representative Date

____________________________________________________________________