# Informal Inquiry for Insurance

| | |
|---|---|
| Client's name: | |
| Date of birth: | |
| Gender: M F | |
| Residential state: | |
| Resident of the United States: Y N | |
| If no, Visa type and provide details: | |
| Current occupation: | |
| Advisor's name: | |
| Advisor's telephone and email: | |
| Current height: | Current weight: |
| Any changes gain/loss of 10lbs in past year: Y N | |
| Plan and amount of insurance being considered: | |
| Current Medications & Dosages: | |
| Tobacco usage past 5 years: Y N | |
| If yes, provide type: | |
| Quantity: | |

| | |
|---|---|
| Motor vehicle violations: Y N | If yes, provide details: |
| Hazard activities: Y N | |
| Foreign travel past 2 years: Y N | |

## Medical History

| Primary Care Dr's Name & Address: | Date: | Reason/Outcome: |
|---|---|---|
| | | |

Have you been treated in the past 10 years for the following?

| | Date | Dr's Name & Address | Reason/Outcome: |
|---|---|---|---|
| Stroke | | | |
| Heart Attack/Coronary Artery Disease | | | |
| Diabetes (current A1C reading) | | | |
| Cancer (type/stage) | | | |
| Diabetes (current A1C reading) | | | |
| Kidney or Liver | | | |
| Alcohol or Drug abuse | | | |
| Other | | | |

| Family Member History | Age(s) if living | Age(s) at death | Cause(s) of death |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| Sisters | | | |

**Submit request with signed authorization to newbusiness@kafl.com or fax to (585) 271-5050**

Please note: In NY, any offers obtained through the informal process are tentative, medical offers that are still subject to the carrier's suitability review through its NYS Reg187 process.

**This is not an application for insurance. It is a preliminary request for determining eligibility of insurance.**

# Authorization To Obtain and Disclose Information

This Authorization complies with HIPAA, HITECH and GLBA Privacy Regulations

The terms that follow have the respective meanings when used in this authorization: Authorization: To obtain and disclose information. Insurance Support Organization: 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, and insurance support organizations, my independent insurance representatives, and those persons and employees authorized to represent them, including those persons defined as "business associates" under the HITECH Act, may need to collect information on me in regard to proposed coverage.**

Accordia Life | AIG / American General | American National | Athene Annuity & Life | AXA Equitable | Banner Life | Global Life | John Hancock of NY | John Hancock USA | Legal & General America | Life Insurance Co. of the Southwest | Lincoln Life of NY | Lincoln National Life | Lincoln National Life of NY | Mutual of Omaha | National Life Group | Nationwide | New York Life | Pacific Life | Penn Mutual | Peterson International | Principal Life Ins. Co. | Principal National Insurance Co. | Protective Life | Protective Life of NY | Prudential Ins. Co. of America | Pruco Life Insurance Co. | Securian | Symetra | United of Omaha | William Penn of NY | Zurich

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"), and any insurer, reinsurer, insurance support organization, financial source, and employer to disclose the types of information listed below when this authorization is presented. I authorize all said sources listed above, except the Bureau, to give such records or knowledge to KAFL Insurance Resources. I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

This information includes my entire medical record and any other **Protected Health Information** concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness, and the use of alcohol, drugs, and tobacco. This also includes information on other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits. This also includes genetic information about me or my family members.

**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 file without restriction.**

My **Protected Health Information** is to be disclosed under this authorization so that the insurance companies named above and their reinsurers may: 1) determine my insurability and underwrite my application for coverage by making eligibility, risk rating, and policy issuance 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 insurance companies named above.

The parties named below 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 services for them.

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 acknowledge receipt of this notice and understand that I have the right to revoke this authorization in writing, at any time, by sending written request to the address listed below. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that any of the insurance companies named above have a legal right to contest a claim under an insurance policy or to contest the policy itself. 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.

**COMPLETED BY INSURED /PATIENT**

Insured's Name Printed: ______________________________ Date: ____________________ DOB: ____________________

Insured's Signature: ____________________________________________________________________________

# PRIVACY POLICY

Protecting your private information is important to KAFL and our employees. We want you to understand what information we collect and how we use it. In order to provide our customers with a broad range of financial products and services as effectively and conveniently as possible, we use technology to manage and maintain customer information. The following policy serves as a standard for all KAFL employees for collection, use, retention, and security of nonpublic personal information.

**COLLECTION OF INFORMATION**

KAFL may be required to collect nonpublic personal financial information about you from some or all of the following sources:

- Information provided by you on applications, new account forms and factfinding questionnaires.
- Transactions executed through KAFL, our affiliates, and other providers with whom we are contracted with and serve as providers, vendors or other parties, deemed necessary to deliver services to you;
- Information from non-affiliated third parties, including, but not limited to consumer reporting agencies;
- Affiliated and unaffiliated product sponsors with whom we have selling agreements in place and/or whose products you currently own.

**DISCLOSURE OF INFORMATION**

KAFL is permitted, under law, to disclose nonpublic personal information about you to other third parties in certain circumstances. For example, we may disclose nonpublic personal information about you to third parties to assist us in servicing your policies or accounts, to government entities in response to subpoenas, and to credit bureaus. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.

Generally, KAFL may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us that supply the products and services requested by you.

<u>Examples of parties with whom KAFL may share your information include:</u>

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to affect purchases and sales and allow for the servicing of your account;
- Your advisor or affiliated financial institutions as permitted by law;
- Third party services for the purpose of interview, exams, medical review or application processing;
- Regulatory or law-enforcement authorities as required by law; and
- Recordkeeping companies

**PROTECTION OF INFORMATION**

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Your information is only available to those requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.

KAFL is not an insurer and does not issue contracts for coverage.

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