

Life's Informal Review™



For Use IF:

Requesting a Policy Face amount of \$10 million or more
and/or if Policy Premium is \$5,000 or more

Informal Inquiry — This is not an application for Life Insurance.

This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds coverage with any insurance carrier.


Borden Hamman Agency
Your Independent Marketing Organization

Personal Information

This Section is **REQUIRED**

Proposed Insured's Full Name _____ M F
 Address _____ City _____ State ____ Zip _____
 Date of Birth _____ Age ____ Social Security # _____ US Citizen Yes No

Occupation / Financial

Occupation: _____ Net Worth: _____ Annual Income: _____

Tobacco/Nicotine Usage

1. Have you ever smoked **cigarettes**? Yes No If yes, date of last usage: ____ / ____ / ____
 2. Have you used **other tobacco** or products containing nicotine? Yes No
 (examples: cigars, pipe, snuff, nicotine gum, beetle nuts, or patch)
 If yes, provide types and last date used: Type: _____ Last date used: ____ / ____ / ____

Family History

This Section is **REQUIRED**

	Age if Living	Age at Death	Current Health Problems or Cause of Death
Father			
Mother			
Brothers			
Sisters			

Has any member of your immediate family been diagnosed on or before age 65 with:

- Heart Disease
- Cancer If yes, please give location of cancer: _____ Result in death Yes No

Senior Citizen

Not Applicable

- A. Yes No Do you live alone? If not, with whom do you live? _____
- B. Yes No Have you been to the emergency room in the last 2 years?
- C. Yes No What are your regular social activities? (church, family gatherings, clubs, etc.) _____

- D. Yes No Do you drive a car?
- E. Yes No Do you do your own grocery shopping?
- F. Yes No Have you fallen in the past 2 years?
 If yes, did you see a doctor? Yes No
- G. Yes No Do you have a cane or a walker ?

Medical Information

This Section is REQUIRED

Height _____ Weight _____ Date of Birth: _____ M F

Physicians you have consulted:

Additional physicians may be listed on bottom of page 3

PRIMARY CARE PHYSICIAN? Doctor's name, address, and phone #	When did you last consult him/her? Why?	Date	Illness
Other physicians you have consulted in the past 10 years: Why? (Do not include insurance examinations.) Doctor's name, address, and phone #			

Medications Currently Being Taken:

Name of Medication	Dosage	Reason

1. Have you EVER been treated for or ever had any known indication of:

- A. Yes No Disorder of eyes, ears, nose or throat?
- B. Yes No Allergies; anemia or other disorder of the blood?
- C. Yes No Deformity, lameness, or amputation?
- D. Yes No Disorder of the skin or lymph glands?
- E. Yes No Cancer, Tumor or Cyst? *If yes, complete the Cancer Questionnaire.*
- F. Yes No Dizziness, fainting, convulsions, headache, speech defect, paralysis, or stroke?
- G. Yes No Mental or nervous Disorder? *If yes, complete the Mental/Nervous Disorder Questionnaire.*
- H. Yes No Shortness of breath, persistent hoarseness or cough, asthma, COPD, emphysema, tuberculosis, or sleep apnea?
- I. Yes No Chest pain, palpitations; high blood pressure; heart murmur, heart attack, or other disorder of the heart or blood vessels? *If yes, complete the Coronary Questionnaire.*
- J. Yes No Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, acid reflux, or other disorder of the stomach, intestine, liver or gall bladder?
- K. Yes No Sugar, albumin, blood or pus in the urine, venereal disease; kidney stone, nephritis or other disorder of the kidney, bladder, prostate or reproductive organs?
- L. Yes No Diabetes, thyroid, or other endocrine disorder? *If yes, complete the Diabetes Questionnaire.*
- M. Yes No Neuritis, sciatica, rheumatism, Arthritis, fibromyalgia, lupus, gout, or disorder of the muscles or bones?
- N. Yes No Ever consulted a doctor or received treatment because of alcohol use?
- O. Yes No Ever been arrested for driving under the influence of alcohol?
- P. Yes No Ever used illegal drugs or sought treatment because of drug use?

*Please provide details for
ALL YES ANSWERS
in space provided
on page 3*

Medical Information (continued)

This Section is REQUIRED

2. IN THE LAST 5 YEARS have you had any of the following tests done?

- | | | |
|---|--|--|
| A. <input type="checkbox"/> Colonoscopy | E. <input type="checkbox"/> Echocardiogram | I. <input type="checkbox"/> Biopsy |
| B. <input type="checkbox"/> Endoscopy | F. <input type="checkbox"/> CT Scan | J. <input type="checkbox"/> Sleep Studies |
| C. <input type="checkbox"/> Stress Test | G. <input type="checkbox"/> X-Rays | K. <input type="checkbox"/> MRI (Magnetic Resonance Imaging) |
| D. <input type="checkbox"/> Pulmonary Tests | H. <input type="checkbox"/> Angiogram | L. <input type="checkbox"/> Abnormal Lab Studies |

*Please provide details for
ALL YES ANSWERS
in space provided
on the bottom of this page*

3. Are you now under observation or taking treatment?

Yes No *If yes, provide details.*

4. Yes No Within the last 5 years has any surgery or test(s) been recommended that have not been performed? *If yes, provide details.*

5. Yes No Have you, within the last 5 years, been a patient in a hospital, clinic, sanitarium, or other medical facility, other than previously listed items? *If yes, provide details.*

6. In the past 10 years have you:

- A. Yes No Had or been told you have or received treatment or advice for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or AIDS related conditions?
- B. Yes No Tested positive for antibodies to the AIDS (Human T-Cell Lymphotropic, Type III; HTLV-III) cell?

Please use the space below for details of preceding questions

Page	#	Date	Details:	Results:



Coronary Questionnaire

Not Applicable

Have you had ANY of the following:

- Heart Attack? Number: _____
date(s): _____
- By-Pass Surgery? date: _____
Number of Vessels: _____
- Coronary Angioplasty? date: _____
Number of vessels: _____
- Heart Failure? Number of Times: _____
Congestive? Yes No
- Valve Surgery? date: _____
Name of Valve _____
- Pacemaker? date: _____
Type: _____

- Elevated Cholesterol? Total chol. level: _____
Chol./HDL ratio: _____
- Family History of heart disease?
- Arrhythmia's?
 - Atrial Fibrillation?
 - Chronic Single Episode
 - Premature Ventricular Beats (PVC's)?
 - Premature Supraventricular Atrial Beats (PAC's)?
- History of Chest Pain?
- Diabetes?
- Height: _____ Weight: _____
- High Blood Pressure?
Highest in last 12 months: _____ / _____

When was the Coronary problem diagnosed? _____

- Date of Surgery: _____
- Date of LAST stress electrocardiogram: _____
 Abnormal Normal By Whom? _____

Were ANY of these tests completed?:

- Stress Electrocardiogram? date: _____ Abnormal Normal Attending Physician: _____
- Echocardiogram? date: _____ Was it done while you were exercising? Yes No
- Thallium Stress EKG? date: _____ Attending Physician: _____
- Coronary Angiogram? date: _____ Number of diseased vessels: _____ Attending Physician: _____

Cancer Questionnaire

Not Applicable

- Location of Cancer: _____ Date of Diagnosis: _____
- Exact Name of Cancer (Sarcoma, Carcinoma, Epithelioma, etc.): _____
- Stage and grade: _____
- Dates/details of treatment/surgery: _____

Who would have the Pathology Report? _____

Please submit a copy of the pathology report for cancer within the last ten (10) years.

- Radiation or Chemotherapy? Yes No Date of last treatment: ____ / ____ / _____
- Has there been any reoccurrence of cancer? Yes No
- IF SKIN CANCER, was it MELANOMA? Yes No Clarks or Breslow's thickness rating: _____



Diabetes

Not Applicable

Date of Diagnosis: _____

Treatment: Name of Medication: _____ Number of Units: _____

Weight: One year ago: _____ Weight now: _____ Height: _____

Do you regularly test your blood or urine for sugar? Yes No

Date of last test: _____ Results: _____

Last Hemoglobin A1C reading: _____ date: _____

Last MicroAlbumin level: _____ date: _____

Have you **EVER** had any of the following:

- A. Yes No Any **EYE** trouble?
- B. Yes No **Heart** trouble?
- C. Yes No High **Blood Pressure**?
- D. Yes No **Kidney** trouble?
- E. Yes No **INSULIN REACTION**?

*Please provide details for
ALL YES ANSWERS
in space provided
on page 3*

Neurological

Not Applicable

Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions:

- A. Yes No Cerebral Atrophy
- B. Yes No Mental Illness
- C. Yes No Depression
- D. Yes No Seizures
- E. Yes No Tremors
- F. Yes No Neuropathy
- G. Yes No Syncope
- H. Yes No Anxiety
- I. Yes No Chronic Fatigue Syndrome

Mental Disorder

Not Applicable

A. Describe your condition: _____

B. Diagnosis: _____

C. Date of first symptoms: _____

D. When did you last see your doctor for this condition: _____

E. Have you been hospitalized? Yes No If yes, When (list all) _____

F. Are you taking any medications? (Give name of Rx and dosage) _____

G. Are you currently employed? Yes No

H. Have mental conditions interfered with your work? If so, how long?

I. Are you disabled? Yes No

**Including but not
exclusive to:**
Depression, Schizophrenia,
Anxiety, Bi-Polar
Disorder, Eating Disorders,
Paranoia, Panic Attacks,
Suicide Attempts

Non - Medical Underwriting Concerns

Aviation — Piloting for business or pleasure

Not Applicable

- A. Select as many as apply:
 Commercial Private Military Student pilot
- B. Type of License: _____
- C. Ratings: IFR (Instrument Flight Rating) VFR (Visual Flight Rating) ATP (Airline Transport Pilot)
- D. Total flying experience: _____
- E. Total hours flown: Last 12 months: _____ Last 24 months: _____
 To Date: _____ Estimate for NEXT 12 months: _____
- F. Type of aircraft used: _____

- G. Any specialized flying: _____
- H. Any flights outside the USA: _____
- I. Scheduled or non-scheduled: _____
- K. Coverage desired: Full coverage Exclusion rider

RELATED ISSUES:
 Any Citations?
 Motor vehicle violations?

Driving History

Not Applicable

- A. Number, dates, and types of infractions (speeding tickets, accidents, reckless driving, etc.):
- B. Dates of any DUI or DWI: _____
- C. Suspensions or revocations: _____
- D. Driver's class after any violations: _____

RELATED ISSUES:
 Current/prior alcohol/drug use
 Treatment for substance abuse
 Any other medical problems

Racing

Not Applicable

- A. Type of Vehicle including make and model:
- B. Type of course:
- C. What type of license do you hold?
- D. Driving as: amateur professional
- E. Total Experience:
- F. Size of engine and type of fuel:
- G. Average and top speed achieved:
- H. Frequency of races: Current year: _____ Previous year: _____ Planned for next years: _____
- I. Name of organization that sanctions the racing:

Including but not exclusive to:
 Motor Vehicle,
 Motorcycle,
 Boat

Non - Medical Underwriting Concerns (continued)

Foreign Travel/Foreign Residency

Not Applicable

- A. Yes No US Citizen?
- B. Country of origin: _____ Citizen? Yes No
- C. Green card? Yes No
- D. Years in USA: _____
- E. Type of Visa: _____ Expiration date: _____
- F. Yes No Own property in the USA?
- G. Travel outside the USA in the past 24 months and future plans:
 - 1. Cities and countries: _____
 - 2. Purpose of visit: _____
 - 3. Frequency and duration: _____

Mountain Climbing

Not Applicable

- A. Locations and frequency of climbs in the last 2 years:
- B. Type of terrain: (i.e., established trails, rock, etc.)
- C. Any climbs outside the US? Yes No *Please give details.*
- D. Ice or glacier climbing? Yes No *Please give details.*
- E. Grade of climbs:
- F. Maximum altitude:
- G. Any specialized climbing equipment used:

RELATED ISSUES:
motor vehicle violations

Scuba Diving

Not Applicable

- A. Total experience:
- B. Any certifications:
- C. Dive alone or with a group?
- D. Member in any clubs:
- E. Depths and frequency of dives:
- F. Location of dives (ocean, lakes, wrecks, rescue, ice, caves):

RELATED ISSUES:
Any medical conditions

AGENT REPORT

This Section is REQUIRED

Agent Information

Agent's name: _____

Phone # _____ Fax# _____

Email address _____

Request Plan of Insurance

This Section is REQUIRED

Universal Life Variable Life Whole Life Term, Level Period _____ Survivorship*

Face Amount Desired: _____

Premium Amount Desired: _____ Annually Monthly

Will these premiums be financed? Yes No

What is the purpose of the insurance? _____

*** For Survivorship ***
Please have the other proposed insured submit a separate copy of Life's Informal Review

PLEASE LIST ALL CURRENTLY INFORCE LIFE INSURANCE POLICIES: (Both personal and business)

Company	Policy # or Application Date	Amount of Coverage	Class / Rating Issued	Current Premium	Do you intend to replace this policy?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

A. If you are replacing coverage, will there be any 1035 money with this replacement? Yes No

If yes, What amount will be carried over? _____

B. Has your client had an application for life, accident, medical or health, disability, or long-term care insurance that was declined, postponed, modified, or rated? Yes No *If yes, provide details*

C. Does your client have an application pending with any other carrier? Yes No *If yes, provide details*

D. Have you or are you asking anyone other than Borden Hamman to review this client for a quote? Yes No

E. Offers from other companies: Attached Written on Fax Coversheet

Agent's Cover Letter

Please tell us about this case ...



Borden Hamman Agency

Your Independent Marketing Organization

Life's Informal Review

Fax Cover Sheet

To: Borden Hamman Agency

Attn: Marian

Fax #: 214-343-3999

Message:

Enclosed please find the Informal Inquiry form for :

Proposed Insured's Name:

Authorization to Obtain and Disclose Information

This authorization is for the Release of Health-Related Information to the Life Insurance Company(ies) and the Borden Hamman Agency (BHA) to be used in the underwriting review process.

I acknowledge that in the event the Company(ies) use lab results from another insurance company authorized by me, it does so with the belief that I have satisfied all consent and disclosure procedures for the other insurance company.

PURPOSE OF AUTHORIZATION

I understand that the information obtained will be used by the Company(ies) to determine my eligibility for life insurance coverage. In addition, information may be disclosed to the Medical Information Bureau (MIB). I understand that the Company(ies) makes the provision of this authorization a condition for the issuance of coverage, and that, while I may refuse to sign this authorization, my refusal to do so could result in an offer for insurance coverage to be withheld.

PROTECTED HEALTH INFORMATION

Protected Health Information is my entire medical record and other health information. It includes information such as: mental and physical health, including facts about communicable diseases such as HIV infection, AIDS, tuberculosis, sexually transmitted diseases and mental illness; prescription drug use; other insurance coverage; hazardous activities; character; and the use of alcohol, drugs, and tobacco.

MY PROVIDERS

My Providers are: any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy database; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf.

I authorize My Providers to disclose my Protected Health Information to the Life Insurance Company(ies) and its(their) agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I made that restrict my Protected Health Information do not apply to this Authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the Life Insurer may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the Life Insurer(s).

This Authorization shall remain in force for 30 months following the date below. A copy or image of this Authorization is as valid as the original. I understand that: 1) I have the right to revoke this Authorization in writing, at any time, by sending a written notice to the Borden Hamman Agency, at 9868 Plano Rd., Dallas, TX 75238, ATTN: Privacy Officer; and 2) written revocation is not effective if any of My Providers has relied on this Authorization or if the Life Insurance Company(ies) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I also understand that any Protected Health Information disclosed pursuant to this Authorization may be re-disclosed and no longer covered by the federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the Life Insurance Company(ies) may not be able to perform the underwriting necessary to provide an offer for life insurance. I acknowledge that I have received a copy of this Authorization.

Signature of Proposed Insured / Patient or Personal Representative

Date

X

Description of Personal Representative's Authority or Relationship to Patient

Life Insurance Company(ies)

American General	Loyal American
AIG Annuity	Met Life
Allianz	Mutual of Omaha
American Equity	National Integrity
American National	North American
Americo	OM Financial (F&G)
AVIVA Life	Presidential Life
AXA Equitable	Principal Group
Banner Life	Protective Life
Borden Hamman Agency	Prudential
EquiTrust	Reliastar Life&Annuity
Fidelity Life	Standard Insurance
Fort Dearborn	Sun Life
Genworth	Symetra Life
Great American	Transamerica Life
ING-USA	US Life
Integrity Life	United Heritage
John Hancock LTC	United of Omaha
Legacy (LMG)	West Coast Life
Lincoln Benefit	Western Reserve Life
Lincoln Financial	William Penn

Privacy Policy of the Borden Hamman Agency Inc.

At the Borden/Hamman Agency, protecting your privacy is very important to us. We value your trust and we want you to understand what information we collect, how we protect it, and how we use it. We treat personal information --- nonpublic information that identifies you --- with respect, and in accordance with this Privacy Policy.

Personal information is essential to provide you with the products and services you request.

Some of our business relationships with outside companies restrict the sharing of personal information with others. If you have obtained a product or service through one of these relationships and we have agreed with that outside company not to share information about you, we will follow those privacy and data sharing restrictions.

Our Privacy Policy

This Privacy Policy is applicable to information practices for Borden Hamman Agency Inc., Borden Hamman Agency of Nevada, Inc., General Agents Marketing Enterprises, and Borden Hamman Agency of Hawaii. This is our Privacy Policy:

- ◆ We will describe in plain English what personal information we collect, how we protect it, and what we may do with it.
- ◆ We will make available to prospective policyholders our Privacy Policy at the time of application, even though we are not required to provide them notice since our services are “necessary to effect, administer, or enforce a transaction requested or authorized by the consumer.”
- ◆ We will maintain physical, electronic, and procedural safeguards to protect any personal information we obtain about prospective insureds and policyowners.
- ◆ We will require other servicing companies to whom we disclose personal information to adhere to our Privacy Policy standards.
- ◆ We will keep nonpublic personal health information confidential but will disclose it to outside companies with your authorization to obtain the products or services you request. We may disclose information, for instance, to companies to underwrite insurance, manage cases, administer and adjust claims, provide quality assurance, conduct research, and investigate fraud.
- ◆ We will give you additional disclosures or obtain your authorization when required by applicable state or federal law.

Please read on for details about our practices for handling and securing your personal information. This Privacy Policy includes examples of the types of information we collect and the kinds of companies with whom we may share information. These examples are illustrative and should not be considered a complete inventory of our information collection or sharing practices.

Information We May Collect

We may obtain information to pass on to other companies to provide you products and services you have requested, to service your coverage, and as we deem appropriate to determine your eligibility for products or services. We may collect identification and contact information, as well as transaction and experience information from applications, transactions with us and with others, and from outside companies. Examples of the sources and types of information we may collect include:

- ◆ Applications, registration forms, or other forms, containing your name, address, telephone number, social security number, e-mail addresses, income, assets, and accounts with others;
- ◆ Your transactions or experiences with us or outside companies, such as your insurance coverage, transaction history, claims history, and premiums;
- ◆ Credit reporting agencies and other companies, such as your obligations with others, your driving record, medical claims, and social security or tax identification number;
- ◆ Other companies, to assist us in marketing our services, may collect information about you and provide it to us such as your name, address and telephone number;
- ◆ You and others, such as information relating to your employment, other insurance coverage, habits, avocation, finances, credit, and other personal characteristics; and
- ◆ Hospitals, doctors, laboratories, and other companies that provide information about your past or present health condition. Health information will be collected as we deem appropriate to determine eligibility for coverage, to process claims, and to prevent fraud, and as authorized by you, or as otherwise permitted or required by law.

Information We May Disclose And To Whom We May Disclose Information

We may disclose all the personal information we collect, as previously described. We may share personal information in the following types of situations:

Disclosures to Insurance Providers

We may disclose all the personal information we collect to insurance companies, reinsurers, administrators, financial services brokers, and others that provide products and services to you, such as:

- ◆ Providing applications, authorizations, illustrations, consents, questionnaires, financial information, physical examinations, lab tests and reports from examiners and personal physicians, attending physician's statements and copies of their respective charts, bank information, and other necessary information to evaluate eligibility for insurance and to issue insurance coverage.
- ◆ Preparing, printing, and delivering policies or statements and other documents on our behalf.

Disclosures To Marketing Firms

We may disclose all the personal information we collect to companies that help us market our products and services.

Disclosures To Outside Companies

We may disclose all the personal information we collect to outside companies for data entry, indexing and imaging of documents, ordering of reports and records of personal history, and other tasks that are necessary in our ordinary business.

Disclosure of Health Information

We may disclose all the health information we collect. We will not disclose it to outside companies that have no connection with your securing the products and services you are seeking. We may disclose information, for instance, to determine eligibility for coverage, to process claims, to prevent fraud, and as authorized by you, or as otherwise permitted or required by law.

Disclosures Permitted by Law

We may also disclose all the information we collect as permitted or required by law. For example, we may disclose information to law enforcement agencies, state insurance authorities, or in accordance with due process.

Our Security Procedures

We maintain procedures and technology designed to prevent unauthorized access to personal information. We maintain physical, electronic, and procedural protections in accordance with applicable standards to protect personal information. We restrict access to personal information to employees, insurers, and service providers for legitimate business purposes to assist in providing products and services to you. Employees who violate our Privacy Policy are subject to disciplinary action.

“Opting Out”

We are committed to protecting personal information, and to using or sharing it in ways that will improve or expand upon the services we provide to you. Our sharing personal information is necessary to obtain the products and services you are requesting. If there is some area, however, that would not prevent those products and services from being provided to you, and you would like to restrict any use of personal information in those areas, you may request through an opt-out response that we not share certain information.

It is important for you to know that this opt-out only applies to the information collected by Borden Hamman Agency Inc. and its affiliates. Personal information obtained outside this agency may be shared with outside companies, provided you have not informed them that you do not wish your personal information shared with these outside companies. This Privacy Policy will not apply to your relationships with other financial service providers, such as insurance agents, insurance companies, and banks. Their privacy policies will govern how they collect, use and disclose personal information that you allow them to access.

How to Notify Us

If you wish to opt out of the sharing of information as described above, you may opt-out by writing to: OPT-OUT, Borden Hamman Agency Inc. at 9868 Plano Road, Dallas, TX 75238. Please include your name, complete address, and telephone number so we may adequately match your information with our database.