LOCAL 215/540-4470
TOLL FREE 800/652-5700
FAX 215/540-4471

UNDERWRITING SPECIALISTS, INC.
451 S. Bethlehem Pike, P.O. Box 409
Ft. Washington, PA 19034-0409

INSURANCE INQUIRY

PROVIDE FULL INFORMATION FOR FAST ACCURATE QUOTATIONS

1. Name (print name in full) ☐ Male ☐ Female

FIRST NAME MIDDLE LAST NAME

2a Birth Date (Mo Day Yr.)	b Place of Birth (State or Country)	c Marital Status

3. Height:_____ ft._____ ins. Weight:_____lbs.

4. Residence address _____Street

_____ (_____Yrs.)
CITY COUNTY STATE ZIP CODE

5. Employer's Name_____ (_____Yrs.)

Business Address_____

Principal occupation (state duties)_____

6. Has the Proposed Insured: Yes or No

(a) Any other application for Life, Accident or Sickness Insurance Pending or contemplated?..... ☐ * ☐
(b) Had any application for Life, Accident, or Sickness Insurance Declined, postponed, modified, or rated; or had a policy canceled Or limited, or its renewal or reinstatement refused?..... ☐ * ☐
(c) Smoked cigarettes in the past 12 months?..... ☐ ☐
(d) Used tobacco in any form in the last 12 months?..... ☐ ☐

7. Insurance desired:

Plan: Amt:

8. Any benefits?
☐ ADB ☐ WPD ☐

9. Who is the proposed Beneficiary? Give name and relationship.

10. Owner, if other than the proposed insured is:

11. How much insurance does Proposed insured have in force?

Co. Name	Amount	Year of Issue	Rated*

12. Are you shopping this case? ☐ Yes ☐ No

Agency _____ Company _____

***Explain & specify likely underwriting problem including the name of the company and offers received on any recent applications.**

If DIABETES or CHEST PAIN involved, **also** complete questionnaires on reverse side

13. a. Name and address of your personal physician: _____

b. Date and reason last consulted: _____ c. Treatment given or medication prescribed: _____

	Name and Address	Date Consulted	Reason
14. Other Doctors attended in the last 10 years.			
15. In what clinics, hospitals or Sanitariums have you been Treated?			

USE SEPARATE SHEET OF PAPER FOR FURTHER DETAILS

Agent's Name _____ Address _____

Telephone # _____ Primary Company _____

Represents: Allianz Life Ins. Co., American General, AXA Equitable, Banner Life Ins. Co., Chase Insurance, Empire General, Fidelity & Guaranty Life, First Colony Life Ins. Co., Genworth Life Ins. Co., Lafayette Life Ins. Co., Lincoln National, North American Company for Life and Health Insurance, Presidential Life Ins. Co., Prudential Life Ins. Co., Union Central Life Ins. Co., U.S. Financial Life Ins. Co., West Coast Life Ins. Co., and William Penn Life Ins. Co.

AUTHORIZATION TO OBTAIN INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health to give any such information to Underwriting Specialists, Inc., the insurance companies Underwriting Specialists, Inc. Represent and their respective reinsuring companies.

I acknowledge receipt of the notice regarding "The Fair Credit Reporting Act" and "Notification Regarding The Medical Information Bureau"

A photographic copy of the authorization shall be as valid as the original.

_____ Veterans Administration Case No. _____
DATE

_____ _____ _____
WITNESS PROPOSED INSURED SOC.SEC.NO.

LEAVE THIS PAGE WITH THE PROPOSED INSURED

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAN (M.I.B.)

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

This information will be treated as confidential except that the companies we represent may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the M.I.B. will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your life. (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 02112, Telephone (617) 426-3660.

The companies we represent may also release information in their file to their reinsuring companies and to other life insurance companies to which you may apply for life or health insurance or to which a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

COLLECTION OF INFORMATION

To underwrite your insurance, information may be collected concerning your age, occupation, physical condition, health history, avocations, or other information necessary to determine appropriate premium rates. We may obtain information from medical practitioners or institutions which have provided care to you or your family and from your employers, business associates, friends, neighbors, other insurance companies, the Medical Information Bureau, (MIB), or from an Investigative Consumer Report prepared by an independent reporting firm. If we request such an Investigative Consumer Report, you have the right to ask to be interviewed and, upon written request, to receive the contents of the report from the reporting company. If the report affects your application as requested, we will so notify you and provide you with the name and address of the reporting firm. Further information on the nature and scope of the reports will be provided upon written request to the President, Underwriting Specialists, Inc., 451 S. Bethlehem Pike, Ft. Washington, PA 19034-0409

Companies Underwriting Specialists, Inc. represents and shares this information with may be any one or all of the following: Banner Life Ins. Co., Chase Insurance, Empire General Life Ins. Co., Fidelity & Guaranty Life, First Colony Life Ins. Co., Lincoln National, MONY, North American Company for Life and Health Insurance, Old Republic Life Ins. Co., Presidential Life Ins. Co., Prudential Life Ins. Co., Union Central Life Ins. Co., U.S. Financial Life Ins. Co., West Coast Life Ins. Co., and William Penn Life Ins. Co.

CHEST PAIN AND DIABETES QUESTIONNAIRE

Name of physician first consulted for chest pain or diagnosed diabetes:

Address of physician:

Name of physician now giving treatment or medical supervision:

Address of phy sician

Date of last visit:

Has electrocardiogram been made?

☐ Yes ☐ No

Date? _____

By Whom? _____

Was it normal? _____

Family record	Living		Deceased	
	Age	Health	At Age	Cause
Father				
Mother				

CHEST PAIN QUESTIONNAIRE

Date of first episode of pain:_____

Have you ever had or been treated for:	Yes	No
a. Chest pain?	☐	☐
b. Skipping of heart?	☐	☐
c. Shortness of breath?	☐	☐
d. High blood pressure?	☐	☐
e. Heart Murmur/Rheumatic Fever?	☐	☐
f. Heart Attack?	☐	☐
g. Coronary Bypass Surgery?	☐	☐
h. Angioplasty?	☐	☐

Where was pain located:

a. Middle of chest?	☐	☐
b. Left side of chest?	☐	☐
c. Left shoulder, arm or hand?	☐	☐
d. Both shoulders or arms?	☐	☐
e. Stomach?	☐	☐

Was pain brought on by:

a. Exertion?	☐	☐
b. Exercise?	☐	☐
c. Excitement?	☐	☐
d. Strain?	☐	☐

Did you have:

a. A sense of pressure or constriction?	☐	☐
b. Sweating?	☐	☐
Was hospital care required?	☐	☐

Give details in Remarks

Have you had more than one episode?	☐	☐

Give number, dates, frequency, and dates of last episode in Remarks.

Are you now, or have you been, on medication such as digitalis, peritrate, nitroglycerin, vasodilators, blood pressure medication, etc?	☐	☐
Do you carry a pill to be placed under the tongue for chest discomfort?	☐	☐

DIABETES QUESTIONNAIRE

Date first Diagnosed:_____

Weight one year ago: _____

What treatment do you use?	Yes	No
Diet only?	☐	☐
Insulin?	☐	☐
Type _____		
Daily Dose _____		
Oral Medication?	☐	☐
Kind? _____		
How many per day? _____		
Do you regularly test your urine for sugar?	☐	☐

Results (please check):

- Usually negative ☐
- Usually trace ☐
- Usually more than trace ☐

Date of last test _____

Result of last test _____

Have you had any blood sugar tests?	☐	☐

Dates: _____

Results: _____

Do you use Glucometer?	☐	☐

Usual range of blood sugar: _____

Have you been treated for:

Insulin reactions?	☐	☐
Diabetic coma?	☐	☐

Have you ever had:

a. Elevated blood pressure?	☐*	☐
b. Heart trouble?	☐*	☐
c. Eye trouble?	☐*	☐
d. Kidney trouble (albuminuria, etc)?	☐*	☐
e. Recurrent infections?	☐*	☐
f. Other prolonged illness?	☐*	☐

*Give details as to dates, physicians attended in Remarks below.

REMARKS:

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

Signature of
Proposed Insured _____ Date _____