

**MA OFFICE**  
 389 Boston Post Road  
 Sudbury, MA 01776-3015  
 978-443-4900 (Local)  
 800-443-4922 (Outside MA)  
 978-443-9804 (Fax)



**PA OFFICE**  
 P.O. Box 148  
 Fort Washington, PA 19034  
 215-793-9440 (Local)  
 877-793-9440 (Outside PA)  
 215-793-9441 (Fax)

**INFORMAL INQUIRY**

This is not an Application for Insurance

Full Name (print) \_\_\_\_\_ Sex \_\_\_\_\_ Plan Of Insurance \_\_\_\_\_ Amount Desired \_\_\_\_\_  
 \$

Date Of Birth \_\_\_\_\_ Place Of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Resident Address \_\_\_\_\_ How Much Insurance In Force Now? \_\_\_\_\_  
 \$

Do you use tobacco of any form? If yes, what type \_\_\_\_\_ Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

Beneficiary (name & relationship) \_\_\_\_\_

Why are you applying on an informal basis? \_\_\_\_\_

**LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:**

Name Of Company	Amount	Year	Annual Premium	Issued?	Extra Premium	Reason Rated or Declined

	NAME & ADDRESS	REASON	DATE
What Physician did you last consult? (Other than insurance examination)			
What Physicians have you consulted during the past 10 years?			
In what hospitals, clinics, or sanitariums have you ever been treated?			
Who is your personal Physician? When did you last consult him?			

AGENT'S NAME \_\_\_\_\_ AGENT'S PHONE NUMBER \_\_\_\_\_

AGENT'S ADDRESS \_\_\_\_\_

**Authorization for Release of Information**

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize The Marcus Insurance Agency, Inc. and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

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 my 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 Marcus Insurance Agency, Inc.. 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.

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 below and their re-insurers as well as The Marcus Insurance Agency, Inc. 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 my Representative to revoke this authorization and that the revocation will take effect when my 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 understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, The Marcus Insurance Agency, Inc. 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 Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

<b>Proposed Insured's Name</b>	<b>Proposed Insured's Signature</b>
<b>Signed and Dated On</b>	<b>At (City, State, Zip Code)</b>

**Agent/ Witness** \_\_\_\_\_

American General, Allianz Life, American National, Aviva, AXA, Banner Life, Companion Life, Fidelity Life, Genworth Financial, ING, John Hancock, Lincoln Benefit Life, Lincoln Financial, Metropolitan Life, Mutual of Omaha, Nationwide, Petersen International, Prudential, ReliaStar Life, ReliaStar Life of New York, Security Life of Denver, Sun Life of Canada, Transamerica, Union Central, United of Omaha, U.S. Life of New York, West Coast Life, William Penn