

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 |
|----------------------|----------------|------------------------|

| | |
|------------------|--------------------------------------|
| Physical Address | Amount of Existing In-Force Coverage |
| | \$ |

Do you use tobacco of any form? **Yes or No** 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 _____

www.themarcusagency.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The Marcus Insurance Agency, Inc. and its staff, affiliated companies and/or entities, including but not limited to RSA Medical, insurance companies and their re-insurers, to possess, obtain and/or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long-term care, or other insurance products.

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 payment, 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, including but not limited to RSA Medical, 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, my prescription records and history of medication prescribed, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with my Providers to restrict my medical records and any associated HIPAA protected health information and I instruct my Providers to release and disclose my entire medical record without restriction. 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 Marcus Insurance Agency, Inc. affiliated insurance companies and their re-insurers. The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices.

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, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Name _____

Proposed Insured's Signature _____

Agent/Witness _____

Signed and Dated on _____

At _____

(City, State, Zip Code)