""""""""""Broker: ___________________________

7/29/2011

owR Opinion's Informal Inquiry for Life Insurance

Return To: nb@owropinion.com, 6 Raritan Road, Oakland, NJ 07436 (phone) 201 651-7700 (facsimile) 201 651-7707

This is not an application for insurance. This form is to be completed and used for the purposes of pre-determining a person's eligibility for life insurance. It should be used in cases where there is a current or past history of a medical disorder or if any prior life insurance application to any company has been modified, adjusted, rated, declined or postponed. If 2 persons are applying for coverage, a separate form should be completed for each person. Use a separate sheet if necessary.

Client Information

Full Name (Print)	**Plan and Amount of Insurance Being Considered**
Date and place of Birth Mo___________ Day ______ Year __________ Country__________________ Male ☐ Female ☐	**Insurance Presently In Force Company/Amount/Year issued**
Current Residence Address	**Current Occupation and Employer's Address**
Height and Weight, Most Recent Blood Pressure and Cholesterol Readings if known and the dates Ft. _______ Inches_______ Weight _________ (date)_________ BP______ (date)___________ Cholesterol ___________ (date) __________ Any Current Medications? (name and dose)	**Has any insurance been applied for in last 12 months?** YES ☐ NO ☐ If Yes, list the companies and the actions taken:
Smoking Habits – Have you ever used Tobacco or Nicotine Substitutes in ANY form? YES ☐ NO ☐ If Yes List Type(s) and Date(s) Last Used:	Please list and fully describe any potentially **hazardous activities** such as, but not limited to, aviation, scuba diving, mountain climbing, skydiving, car racing, etc. Include type, total hours in past & anticipated in future, certifications etc.

Medical History	Primary Care Doctor(s) Name, Address and Phone #	Date(s) Last Consulted and Why
Please provide the name and address of your primary care physician. as well as any other physicians consulted in the last 10 years for any of the following conditions, any disease or disorders of: **A)**Heart or blood vessels including elevated lipids and hypertension, **B)**Cancer **C)**Nervous system **D)**Respiratory system, **E)**Gastrointestinal or urinary systems including the liver or kidneys **F)**Endocrine system including Diabetes **G)**Any mental disorder Any other doctors for any other conditions		
Details of any Motor Vehicle violations in past 5 years		
Foreign Travel — Past 2 years:		
Foreign Travel — Anticipated in next 2 years:		

Family History	Name(s)	Age(s) if Living	Age(s) at Death	Cause(s) of Death	Medical History and age at Diagnosis
Father					Cancer ☐ ______ Heart Disease ☐ ______ Diabetes ☐ ______
Mother					Cancer ☐ ______ Heart Disease ☐ ______ Diabetes ☐ ______
Brothers					Cancer ☐ ______ Heart Disease ☐ ______ Diabetes ☐ ______
Sisters					Cancer ☐ ______ Heart Disease ☐ ______ Diabetes ☐ ______

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION - HIPAA COMPLIANT

____ ____________________

Name of Proposed Insured/patient (Please type or print) Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, 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, prescription history, medications prescribed, and any other protected health information concerning me to owR Opinion LLC and the insurance companies and/or settlement companies named below. 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 to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the companies, insurance, settlement, or others named below 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 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 and/or settlement companies named below.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to owR Opinion, L.L.C., at 6 Raritan Road, Oakland, NJ 07436, Attn: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that the insurance and/or settlement companies named below 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies and/or settlement companies named below except as authorized by me or as required by law.

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 or release my complete medical record, the companies, insurance, settlement, or others named below may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

21st Services
Advanced Settlements, LLC
Allstate
American General Life (AG)
American National
American Viatical Services, LLC (AVS)
Aviva Life and Annuity Company of NY
AXA / Equitable Life Insurance Co.
Banner
Companion Life
Coventry First
Empire General
EMSI
Fasano
Fortis
Genworth Life
Genworth Life & Annuity
Genworth Life of New York
The Hartford
IBU, Inc.
ING / Reliastar Life
ING / Reliastar Life of NY
ING / Security Life of Denver
Jackson National of NY
John Hancock Life Ins Co.
John Hancock Variable Life Ins Co.
John Hancock Life Ins Co. (USA)
John Hancock Life Ins Co. of NY
The Life Settlement Co. of America LLC
Lincoln Benefit Life
Lincoln Life of NY
Lincoln National
MassMutual Life Insurance Co.
MetLife
Minnesota Life
Nationwide Life Insurance Co.
Nationwide L & A Co.
New York Life
Ohio National
Pacific Life
Phoenix Life Insurance Co.
Phoenix L & A Co.
Presidential
Principal Life
Principal National
Prudential
SBLI of MA
Securian Life
Security Mutual
Sun Life Financial
Transamerica Life Insurance
Union Central
United of Omaha
United States Life
Universal Underwriters Life Insurance Co.
UNUM
Welcome Funds, Inc.
William Penn
West Coast Life
XE-Capital Management, LLC, its affiliates, professional advisors and consultants
XE-R, LLC
Zurich American Life Insurance Company

____ ________________________

Signature of Proposed Insured/Patient or Personal Representative Date

____

Description of Personal Representative's Authority or Relationship to Patient

Revised 07/2011
owR Form B

NOTE: This Authorization needs to be signed <u>in addition to</u> the Authorization to Obtain and Disclose Information.