VICTORSON ASSOCIATES, INC.
the professional's choice

PRELIMINARY INQUIRY – NOT AN APPLICATION FOR LIFE INSURANCE

PERSONAL HISTORY

Name _____ ☐ Male ☐ Female Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone: _____ Business Phone: _____

Date of Birth _____ Age _____ Height _____ Weight _____

When last used tobacco? Cigarettes _____ Cigars _____ Other _____

Hazardous Activities: Private Pilot: ☐ Yes ☐ No Scuba Diving: ☐ Yes ☐ No Sky Diving: ☐ Yes ☐ No

Family Health History:	Age (If deceased, age at death)	History of heart disease or circulatory disorder		History of cancer, all types	
Mother		☐ Yes	☐ No	☐ Yes	☐ No
Father		☐ Yes	☐ No	☐ Yes	☐ No

REQUESTED PLAN OF INSURANCE – MUST BE COMPLETED

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship

Face amount desired $ Premium Amount desired $

MEDICAL HISTORY – THIS SECTION MUST BE FULLY COMPLETED

1. Who is your personal physician?	Doctor's name, address and phone number	When did you last consult him/her? Date	Reason
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations)			
3. In what clinics, hospitals, or sanitariums have you ever been treated?			

4. Please list all current medications:

Has the person to be covered had:

		YES	NO
A.	Epilepsy, fainting spells, nervous or mental condition, neuritis, paralysis, or any disease or abnormality of the brain or nervous system?	___	___
B.	Heart attack, murmur, palpitations, or high blood pressure, anemia, varicose veins or any disease or abnormality of the heart, blood or blood vessels?	___	___
C.	Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, throat or respiratory system?	___	
D.	Ulcer, indigestion, colitis, gall stones, hernia or any disease or abnormality of the stomach, intestines, rectum, gall bladder or liver?	___	___
E.	Urinary sugar, albumin or stone, syphilis, menstrual disorder, or disease or abnormality of the breasts, kidneys, prostate urinary or genital systems?	___	___
F.	Diabetes, gout, or any disease or abnormality of the thyroid or other glands?	___	___
G.	Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?	___	___
H.	Any disease or abnormality of the eyes, ears, or skin?	___	___
I.	Cancer or tumor?	___	___
J.	Any physical deformity or defect?	___	___
K.	Any immune deficiency disorder, been diagnosed as having ARC or AIDS caused by HIV infection or other sickness or condition derived from such infection or tested positive for exposure to the HIV infection?	___	___
L.	Decline or rating for life insurance	___	___
M.	Rating for life insurance	___	___

FOREIGN TRAVEL

Do you plan to travel or live outside of the US in the next 5 years? ☐ YES ☐ NO

If so, where and for how long? _____

AGENT INFORMATION

Name _____ Firm Name _____ SSN#_____

Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Please send your completed documents to: Victorson Associates, Inc. PO Box 863 Smithtown, NY 11787 Attn – Underwriting
Phone – 631-265-7456 Fax – 631-265-7054 Email – info@victorson.com

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured: _____

ALLIANZ	MASS MUTUAL
AMERICAN MEMORIAL	MET LIFE INSURANCE COMPANY
AXA	MINNESOTA LIFE INSURANCE COMPANY
AMERICAN GENERAL	NATIONAL LIFE OF VERMONT
AMERICAN NATIONAL	NORTH AMERICAN
AMERITAS LIFE INSURANCE COMPANY	PRINCIPAL FINANCIAL
ASSURITY LIFE INSURANCE COMPANY	PROTECTIVE LIFE AND ANNUITY
AVIVA LIFE INSURANCE COMPANY	PRUDENTIAL FINANCIAL
BANNER LIFE INSURANCE COMPANY	SECURITY MUTUAL LIFE INSURANCE COMPANY
COLUMBIAN MUTUAL LIFE INSURANCE COMPANY	STATE LIFE
COMPANION LIFE	SUN LIFE
FIRST AMERITAS LIFE INSURANCE COMPANY	TRANSAMERICA
FIRST MET LIFE INVESTORS LIFE INSURANCE CO.	US FINANCIAL
GENWORTH LIFE INSURANCE COMPANY	US LIFE INSURANCE COMPANY
GENERAL AMERICAN LIFE INSURANCE COMPANY	UNION CENTRAL
GUARANTEE TRUST LIFE INSURANCE COMPANY	UNITED OF OMAHA
GUARDIAN LIFE INSURANCE COMPANY	VICTORSON ASSOCIATES, INC.
JOHN HANCOCK	WEST COAST LIFE INSURANCE COMPANY
ING RELIASTAR LIFE INSURANCE COMPANY	WILLIAM PENN LIFE INSURANCE COMPANY
LINCOLN NATIONAL	

I understand that any Company named above, its reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits

If for a Lifetime Settlement, I understand that settlement providers and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy of which I am the owner, or which I am the insured, and I hereby expressly authorize such use and disclosure.

Signed at _____ this _____ day of _____ 20____

_____ Proposed Insured Signature

_____ Proposed Owner's Signature

If minor children are proposed for coverage, the person authorized to act on their behalf makes the above statements.

_____ Name of Minor Child

_____ Signature of Minor Child's Authorized Representative

Name of Minor Child's Authorized Representative

_____ Witness (Broker)

_____

Authorization for Release of Health-Related Information - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
_____	_____
_____	_____
_____	_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, 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 and any other personal health information concerning me to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). 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. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies 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 Companies.

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 sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies 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 may be re-disclosed and no longer covered by 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 complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____	_____
Signature of Proposed Insured, Patient, or Personal Representative	Date
_____	_____
Signature of Proposed Insured, Patient, or Personal Representative	Date
_____	_____
Signature of Proposed Insured, Patient, or Personal Representative	Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Authorization for Release of Personal Psychotherapy Notes - This authorization complies with the HIPAA Privacy Rule

Name of Persons covered by this Authorization	Date of Birth
_____	_____
_____	_____
_____	_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, 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 and any other personal health information solely relating to psychotherapy notes to any of the companies listed above, its agents, employees, and representatives (collectively referred to as "The Companies"). Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record as described above without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies 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 Companies.

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 sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies 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 may be re-disclosed and no longer covered by 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 complete medical record as described above, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

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