INFORMAL APPLICATION *This form must be submitted with a MRW Financial HIPPA*

Date:

Agent Name: _____

City & State: ***(App Signed)*** _____

1. PERSONAL HISTORY

a. Client's Full Name: Male ☐ Female ☐	b. DOB	c. Social Security Number	d. Height/Weight	e. Occupation

f. Mailing Address including City, State and Zip:	g. DL# & State

2. PRIMARY CARE PROVIDER

a. Name and Address	b. Telephone Number

c. Date Last Seen	d. Reason for Visit	d. Diagnosis

3. MEDICAL HISTORY

List all doctors seen in the last five years:

DOCTOR NAME /ADDRESS & PHONE	DATE	REASON FOR VISIT	DIAGNOSIS

3. ACTION OR TABLE RATING OFFERED BY ANOTHER CARRIER

Have you ever been **declined** or **rated** by an insurance company for coverage? ☐ Yes ☐ No

Company	Date	Rating/Declined	Reason (please be specific)

4. REQUESTED INSURANCE ***(THIS SECTION MUST BE COMPLETED)***

Plan: Term ☐ Years? UL ☐ SUL ☐ *(complete separate form for add'l insured)*	1035 Exchange? ☐ Yes ☐ No	Est. $ Amt:
Face Amount:	Anticipated Premium:	Do you have an illustration? ☐ Yes ☐ No *(If "Yes" please provide a copy)*
Rate Class Applied for:	Any Riders? (please list)	If MRW Financial ran illustration, who?

5. MEDICATIONS

List all medications, reasons for medication and dosage currently being taken:

Name of Medication	Current Dosage	Reason for medication

6. FAMILY HISTORY

Family Member	Age if Living	Age at Death	Details
☐ Father			
☐ Mother			
☐ Siblings			

7. FOREIGN TRAVEL

Where	When	Length of Stay	Details

INFORMAL APPLICATION - Questionnaire Details

Agent Name:
Date:

Attach additional copies as needed.

PROPOSED INSURED

a. Client's Full Name: | DOB:

8. MEDICAL QUESTIONS ***(EXPLAIN ANY "YES" ANSWERS USING THE QUESTIONNAIRE DETAILS FORM)***

a. Have you ever had, been treated for, or been medically advised to be treated for, any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	**Cancer** *(Choose Type)*	Yes	No
1. Alcohol Abuse			11. CAD/Heart Attack/Heart Surg.			21. Kidney Disease			a. Breast		
2. Alzheimer's			12. Crohn's Disease			22. Lupus			b. Colon		
3. Anxiety			13. Depression			23. Multiple Sclerosis			c. Leukemia		
4. Arthritis (General/Rheumatoid)			14. Diabetes (Type I or II)			24. Parkinson's			d. Lung		
5. Asthma			15. Drug Abuse			25. Peripheral Vascular Disease			e. Lymphoma (Hodgkins)		
6. Atrial Fibrillation			16. Elevated Liver Functions			26. Sleep Apnea			f. Lymphoma (Non-Hodgkins		
7. Cerebrovascular Disease			17. Epilepsy/Seizures			27. Stroke			g. Ovarian		
8. Cirrhosis			18. Heart Murmur/Valve Disease			28. Weight Reduction Surgery			h. Prostate		
9. Colitis/Gastritis			19. Hepatitis (Type A, B or C)			29. Sugar, Protein, or Blood in Urine			i. Skin		
10. COPD			20. Irreg. Heartbeat/Palpitations						j. Other		

	Yes	No
b. In addition to the above conditions, in the past 5 years have you:		
(1) Consulted with or received treatment from a care provider or treatment facility?		
(2) Had an EKG, X-ray or other diagnostic test?		
(3) Been advised to have any diagnostic test, hospitalization or surgery that was not completed?		
(4) Had medication prescribed for a physical or mental disorder?		
c. Is there a history of diabetes, cancer, high blood pressure, heart or kidney disease, alcoholism, mental illness, or suicide in your family?		
d. Have you received a DUI or any speeding tickets in the last 3 years?		
e. Other than prescribed by a physician, have you ever used marijuana, narcotics, stimulants, sedatives, hallucinogens or any prescription drugs?		
f. Do you participate in any aviation, scuba, sky-diving, or any other hazardous sports?		

g. Mark the one item that best describes your history of **alcoholic beverage** use: ☐ **Never Used** ☐ **Totally Stopped** ☐ **Use Now**

(1) If you have "Totally Stopped," indicate the number of years since you totally stopped and give date & reason in the Questionnaire Details Form

(2) If you "Use Now," how often do you drink alcoholic beverages? ☐ **Occasionally** ☐ **3 or less days per week** ☐ **4 or more days per week**

(3) If you "Use Now," how many drinks do you consume per day? ☐ **3 or less** ☐ **4-6** ☐ **7 or more**

h. Mark the one item that best describes your history of **tobacco** use: ☐ **Never Used** ☐ **Totally Stopped** ☐ **Use Now**

(1) If you have "Totally Stopped," indicate the type of tobacco used and give the date of last use in the Questionnaire Details Form.

(2) If you "Use Now," describe the type _____ *and amount used* _____.

i. (a) Do you engage in or plan to engage in any **Foreign Travel**? ☐ Yes ☐ No (b) Do You Reside in a Foreign Country? ☐ Yes ☐ No

(1) If "yes" to either question please provide details in Section 7.

j. Are you a United States citizen? ☐ Yes ☐ No

9. MEDICAL QUESTIONS DETAILS

Question #	Condition	Duration (M/D/Y to M/D/Y)	Describe Diagnosis, Treatment, Medications, Tests & Results and any additional details *(Provide name and address for any Care Provider/Treatment Facility)*

10. ADDITIONAL COMMENTS

Authorization Form

This Authorization is HIPAA compliant

Date:_____ Advisor Name:_____ Advisor Phone: ( ) _____

Insured Name:_____ Date of Birth:_____

SSN:_____ Driver's License #:_____ State: _____

The purpose of this Authorization is to permit MRW Financial to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below.

I specifically authorize any physician or other medical practitioner, hospital, clinic, or other health-related facility, medical testing laboratory, insurer, state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has information or documentation about me to release such information and documentation to MRW Financial and its authorized representatives. The information and documentation to be released to MRW Financial shall specifically include any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, including but not be limited to, documents relating to my mental and physical health, mental health records, psychotherapy notes, drug/ alcohol abuse treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("Information").

In addition, I specifically authorize MRW Financial to release any and all Information it receives about me to the companies listed below. I also specifically authorize MRW Financial and the companies listed below to release any and all Information about me to their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB*) to release any and all Information about me directly to any company listed below, upon such company's request, provided the company is a member of MIB.

This Authorization shall be effective for two (2) years after the date signed below. I understand that I have the right to revoke this Authorization at any time by sending a written notice of revocation to MRW Financial, 310 S. Dale Mabry Hwy., Ste. 210, Tampa, FL 33609. I understand that any action taken in reliance on this Authorization prior to MRW Financial's receipt of the written notice of the revocation shall be valid. I also understand that any Information that is used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy rules.

I understand that execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand that my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the companies below.

I acknowledge that I have read and understand the above and agree that this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by MRW Financial and/or any third party designated herein.

_____

Proposed Insured's Signature / Guardian or Custodian / Authorized Representative Date

_____

Broker / Advisor / Agency / Firm Signature Date

AIG / American General	Gleaner	MetLife DI	Protective Life of NY
AIG Annuity Access	Guarantee Trust Life	MetLife LTC	Prudential Life
Allianz	Illinois Mutual	Midland National	Reliance Standard
Allianz Life of NY	ING Northern Life	Minnesota Life	Savings Bank Life Insurance
Allstate Life of NY	ING Reliastar	MRCS	Co of MA
American National	ING Reliastar of NY	Mutual of Omaha	Security Mutual of NY Standard
American Investors Life	ING Security Life of Denver	National Guardian	Insurance Company State Life/
Acuity	ING Annuity and Life	National Integrity Life	One America
AVIVA AXA Equitable	Integrity Life	National Life	Sun Life Financial
Banner Life	John Hancock Life	Nationwide – Provident Mutual	Sun Life of Canada
Companion Life of NY	John Hancock LTC	New York Life	Sun Life of NY
Dearborn National	John Hancock of NY	North American	Transamerica
Equitable Life and Casualty	John Hancock USA (MAN)	OM Financial Life Insurance Co.	UNIFI Companies
Equitrust	Lafayette Life	OM Financial Life Insurance	United of Omaha
Fidelity Life	Life of the Southwest	Co.of NY	US Life on New York
Fidelity Security	Lincoln Benefit	Pacific Life	West Coast Life
Genworth Life	Life Lincoln Life of NY	Penn Mutual	Western Reserve Life
Genworth Life & Annuity	Lincoln National	Petersen International	William Penn of NY
Genworth Life and Annuity Ins.Co.	Lloyd's of London	Phoenix Life Insurance Co.	Zurich
Genworth Life Ins. Co of NewYork	MassMutual	Presidential Life Principal	
Genworth Life NY	MedAmerica	Principal National	
Genworth LTC	MetLife Investors	Protective Life	

Other Company: _____ Insured Initials: _____

MRW Financial will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured. *MIB is a not for profit organization of life insurance companies and operates an information exchange or its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. MIB, Inc. PO Box 105 Essex Station, Boston, MA 02112 or call (617) 426-3660

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