



INFORMAL INQUIRY

NOT AN APPLICATION FOR LIFE INSURANCE

APPLICANT INFORMATION

Name		Date	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height	Weight
Address			City, State, Zip		
Daytime Telephone Number			Evening Telephone Number		
Face Amount	Product Type	Income	Net Worth		Date of Birth
Producer Name		Producer Telephone		Producer e-mail	

INSURANCE CURRENTLY IN FORCE

Insurance Company	Personal or Business	Year Issued	Face Amount	Replace?

Do you have plans for foreign travel? Yes No If yes: where, when, why and how long: _____

Have you ever used any kind of tobacco or any other nicotine products? Date last used: _____
 cigarette pipe nicotine gum/patch cigar (how many per year____) chew

Do you have any knowledge that an application or informal inquiry has been seen by any carriers within the last year?
 Yes No If so, please list name of carrier, offer or declined: _____

APPLICANT MEDICAL INFORMATION

Do you have a history of	Yes	No	Do you have a history of	Yes	No
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cerebrovascular Accident/TIA	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition/Coronary Artery disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Human Immunodeficiency Virus ((HIV) infections	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immunodeficiency Syndrome (AIDS)	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>

CANCER: Have you been diagnosed with cancer? Yes No If yes, when? _____
 Location: _____ What stage? _____
 Was there a biopsy? Yes No Radiation or chemotherapy dates: _____
 What physician would have the pathology report? _____

DIABETES: Have you been diagnosed with diabetes? Yes No If yes, at what age? _____
 Current therapy and doses: Diet only Insulin Oral medication _____

Have your parents or siblings ever had cancer, diabetes or heart disease? Yes No

Did any die prior to age 60 due to any of these conditions? Yes No

Additional Medical Information and Medications (please include dates for medical information and dosage for medication):

PHYSICIAN INFORMATION: Please list all physicians seen within the past ten (10) years:

Name: _____ Phone: _____

Address: _____

Date Last Seen: _____ Reason: _____

Name: _____ Phone: _____

Address: _____

Date Last Seen: _____ Reason: _____

Insured Net Worth Statement

Assets

Residence	\$ _____
Real Estate	\$ _____
Business Interest	\$ _____
Partnership Interest	\$ _____
Cash	\$ _____
Marketable Securities	\$ _____
Collectibles	\$ _____
Other	\$ _____
Qualified Plan Assets	\$ _____
Total Assets	\$ _____

Liabilities

Mortgage	\$ _____
Personal Debt	\$ _____
Business Debt	\$ _____
Other	\$ _____
Total Liabilities	\$ _____

Net Worth (Assets – Liabilities) \$ _____

Annual Earned Income \$ _____

Annual Unearned Income \$ _____

Premium Finance Information

Type of loan applying for:

Traditional fully collateralized _____
Hybrid reduced collateral _____

Duration of loan term:

2 – 5 years _____
5 – 10 years _____
10 years + _____
For life _____

Interest Payments

Deferred _____ If yes, for how many years (typically 10 max)? _____
Upfront _____
Arrears _____

Type of Collateral

Cash or Equivalent (CD, money market, etc.) _____
Marketable Securities (i.e. stocks, bonds, etc.) _____
Letter of Credit _____
Personal Guarantee (available with Hybrid programs) _____

Insured Family Information

Spouse _____
Children _____ If yes, how many _____
Grandchildren _____ If yes, how many _____

Other Questions

Is insured's lifetime gifting exemption intact? _____ If no, how much is left? _____
Has the insured ever financed a policy before? _____ If yes, please provide details:

Are there are other details, needs, considerations, etc, that would be relevant to the insured's situation? If so, please provide additional information below:



AUTHORIZATION

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give the Insurance Companies named below any and all such information. To facilitate rapid submission of such information, I authorize all said sources, except The Medical Information Bureau, Inc. to give such records or knowledge to 3 Mark Financial.

I UNDERSTAND 3 Mark Financial will use the information obtained by use of this Authorization and/or the Insurance Companies named below to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by 3 Mark Financial or the Insurance Companies named below to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, life expectancy evaluation or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

3 MARK FINANCIAL REPRESENTS: Allianz Life, AIG Life, American General, American National, Assurity, Aviva Life, AXA, Banner Life, Columbus Life, Conesco, Coventry, Fidelity & Guaranty Life, First Penn, Genworth Financial Assurance, Guarantee Trust Life, Hartford, IAP, ING Life Companies, Jefferson National, John Hancock, Kansas City Life, Lafayette Life, Life of Southwest, Lincoln Benefit Life, Lincoln Financial Group, Maple Life, MetLife, Monumental, Nationwide, New York Life, North American, Pac Life, Peachtree, Penn Mutual, Phoenix Life, Principal, Protective Life, Prudential, SBLI, Security Mutual, Sun Life, Transamerica, Union Central, United of Omaha, West Coast Life, Western Reserve, William Penn.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE this Authorization shall be valid for two years from the date shown below.

Signed this _____ day of _____, 20_____

X _____

Signature of Proposed Insured/Parent or Guardian

Printed name of Proposed Insured/Parent or Guardian
