



# 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	\$ _____
<b>Total Assets</b>	<b>\$ _____</b>

### Liabilities

Mortgage	\$ _____
Personal Debt	\$ _____
Business Debt	\$ _____
Other	\$ _____
<b>Total Liabilities</b>	<b>\$ _____</b>

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:

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

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# AUTHORIZATION

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## 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, IA, 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 Life Insurance, Principal National Life Insurance, 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

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Printed name of Proposed Insured/Parent or Guardian

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