The Horan Agency
Life-Health-Wealth Solutions

PLEASE USE BLACK INK ONLY

Personal Information Page

Please complete this form in its entirety. Missing information may delay the establishment of your policy.

Personal Information

Name: Sex: Male / Female

Date of Birth: Social Security #

Birthplace: Citizenship:

Home Address:

Home Phone: Work Phone:

Cell Phone: Email:

Drivers License # Drivers License State:

DL Issue Date: DL Expiration Date:

Annual Earned Income: Unearned Income Net Worth:

Liquid Assets: Federal Income Tax Bracket:

Name of Employer:

Employer Address:

Personal History Questions

1. Do you anticipate any foreign travel within the next 2 years? ☐ Yes ☐ No
2. Within the last 3 years have you been, or within the next 2 years do you expect to become a pilot? ☐ Yes ☐ No
3. Within the last 3 years have you taken part in, or within the next 2 years expect to take part in any hazardous activities or extreme sports (diving, hang gliding, para sailing, skydiving…)? ☐ Yes ☐ No
4. Within the last 5 years, have you been in a motor vehicle accident or convicted of a moving violation? ☐ Yes ☐ No
5. Within the last 10 years, have you been convicted of operating a motor vehicle while under the influence of alcohol or drugs? ☐ Yes ☐ No
6. Have you ever been convicted of a felony, or currently on parole or probation? ☐ Yes ☐ No

If you answered yes to any of the questions above, please provide explanation below.

_____

_____

_____

_____

Account Information

Primary Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Primary Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 1

Name: Relationship: Social Security #

Date of Birth: Percent:

Contingent Beneficiary 2

Name: Relationship: Social Security #

Date of Birth: Percent:

In Force Life Insurance

Date Issued: Carrier: Type:

Insured: Face Amount: Policy #

Spouse:

Siblings (If Juvenile Insured):

Additional Requirements for Disability Insurance:

Employer Paid Benefits

Plan Design:

Benefit Amount: Benefit Period:

Elimination Period: Other Individual Coverage:

Number of Employees: Owner:

Individual Disability Income insurance

Client information form

The Horan Agency
Life-Health-Wealth Solutions

DFS
DOCTORS FINANCIAL SERVICES

For pre-screening, illustrations or application needs

Basic information

Name: _____ Date of birth: _____ Gender: _____

Permanent address: _____ City: _____ State: ____ Zip: _____

Phone number: _____ Email address: _____

Occupation

Occupation title: _____ Years in position: _____

Amount of physical work in current position: ○ Low (0-30%) ○ Moderate (31-60%) ○ High (61-100%)

Explain job duties: _____

_____

Salary/bonus income (prior year): $_____ Other income: $_____

Unearned income: $_____ Work from home: ○ No ○ Yes

Self-employed: ○ No ○ Yes

If yes: How long: _____ Number of full-time (30+ hrs/wk) employees: _____

Percent of ownership: _____

Other coverage

Do you have other disability coverage: ○ No ○ Yes If yes, provide details:

Benefit amount	Maximum benefit	Elimination period	Benefit period	Paid by (your employer or you)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	This form is HIPAA compliant

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, LIFE Brokerage, LLC, brokers, contractors, employees, representatives and agents working through LIFE Brokerage, LLC for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies			
Advantage Insurance Network, Inc.	First Penn	Lincoln Financial/ Lincoln Life	Professional Underwriting Services
Allianz	Foresters	Lincoln National Life Insurance Co.	Protective Life Ins Co.
American General Life (AIG)	Global Insurance Underwriters	Massachusetts Mutual	Prudential Life Ins. Co. / Pruco Life
American National	GE Financial Assurance Co.	Metropolitan Life	RSA Medical SBLI
Americo	Genworth Life Insurance Co.	MetLife Investors USA Insurance Co.	Security Mutual
Assurity Life	Genworth Life and Annuity	Minnesota Life / Securian	Standard Life
Aviva / Indianapolis Life	Guardian Life Ins. Co.	Mutual of Omaha	Sun Life Ins. Co. of America
Ameritas	Hartford Life Insurance Co.	National Life of Vermont	Sun Life Ins. Co. of Canada
AVS, LLC	Industrial Alliance Pacific	National Western	Superior Medical Group
AUS Underwriting	ING - ReliaStar Life of New York	Nationwide Life & Annuity Co.	Symetra
AXA / MONY / AXA Equitable	ING – ReliaStar	New York Life Insurance Co.	Transamerica Life Insurance Co.
Banner Life	ING – Security Connecticut Life	North American Co.	Travelers Life & Annuity
Cavalier Associates	ING - Security Life of Denver	Old Mutual Financial Network	21st Services
Columbus Life	ISC Services	Pacific Life	Union Central Life
Coventry First, LLC	John Hancock Life Ins. Co.	Penn Mutual	United of Omaha
Double A Brokerage, LLC	John Hancock USA	Premium Funding Group (PFG)	USG Annuity & Life
Fasano Associates, Inc.	Lafayette Life	Pioneer Mutual	West Coast Life Insurance Co.
Fidelity & Guaranty Life Ins. Co.	LIFE Brokerage, LLC	Phoenix Life	Western Reserve Life
First Global Financial & Insurance	Life Insurance of the Southwest	Presidential Life	William Penn Life Ins. Co.
First Heartland	LifeShare	Principal Life Insurance	Zurich American Life Insurance Company
First Insurance Funding	Lincoln Benefit Life	Principal National Life Insurance	
Additional Insurers and Agencies:			

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____,

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to LIFE Brokerage, LLC, the Insurers and Agencies listed afore and to:

Agent/Producer Name: _____.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement ompanies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____ Printed Name: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation; personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.

MEDICAL INFORMATION

Please include the name, address, and telephone number of each physician listed.

Personal Primary Care Physician: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
Specialist: Name: Address:	Telephone Number:	Date of Last Visit:	Reason for Visit:
List any Clinics or Hospitals Name: Address:	Telephone Number:	Date of Admission:	Reason for Admission:

List all current medications:_____

_____

_____

Non Medical Questions

PI1 1. Height (in shoes) _____ft._____in. 2. Weight (clothed) _____lbs. Weight change in last year? ☐ Yes ☐ No If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

PI2 3. Height (in shoes) _____ft._____in. 4. Weight (clothed) _____lbs. Weight change in last year? ☐ Yes ☐ No If Yes, ☐ Increase ☐ Decrease No. of lbs. _____

	PI1	PI2
5. Are you presently taking any medication, supplements or homeopathic remedies either prescribed or over the counter?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the past 10 years, has a licensed member of the medical profession treated you for, or made a diagnosis of:		
a. High blood pressure, chest discomfort, heart attack, heart murmur, circulatory or heart disorder?	☐ Yes ☐ No	☐ Yes ☐ No
b. Diabetes, sugar in urine, thyroid disorder, elevated cholesterol or other endocrine or metabolic disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Asthma, bronchitis, emphysema, shortness of breath, sleep apnea or any other lung or respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
d. Hepatitis, cirrhosis, ulcer, colitis or other disorder of the stomach, liver or digestive system?	☐ Yes ☐ No	☐ Yes ☐ No
e. Anemia, leukemia or other blood or clotting disorder?	☐ Yes ☐ No	☐ Yes ☐ No
f. Arthritis, gout, back or joint pain, bone fracture, muscle disorder, or any disorder of the skin?	☐ Yes ☐ No	☐ Yes ☐ No
g. Seizures, stroke, fainting, paralysis, falls, loss of consciousness, mental or emotional disorder or any other disorder of the brain or nervous system?	☐ Yes ☐ No	☐ Yes ☐ No
h. Alzheimer's disease, dementia, memory impairment, Parkinson's disease or any other progressive neurological disease?	☐ Yes ☐ No	☐ Yes ☐ No
i. Cancer, tumor, polyp or cyst?	☐ Yes ☐ No	☐ Yes ☐ No
j. Disorder of eyes, ears, nose or throat?	☐ Yes ☐ No	☐ Yes ☐ No
k. Kidney, bladder, urinary, reproductive organ, breast or prostate disorder?	☐ Yes ☐ No	☐ Yes ☐ No
l. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system or a positive blood test for antibodies to the HIV virus?	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you ever used any controlled substances such as: amphetamines, barbiturates, hallucinogens, heroin, morphine, cocaine, marijuana, opiates or any prescription drug, except as prescribed by a physician? If yes, please complete Substance Use Questionnaire PM0293.	☐ Yes ☐ No	☐ Yes ☐ No
8. Have you ever been advised to limit or discontinue the use of alcohol or drugs, sought or received treatment, counseling or participated in a group for alcohol or drug use? If yes, please complete Substance Use Questionnaire PM0293.	☐ Yes ☐ No	☐ Yes ☐ No
9. Other than previously stated, have you within the past 5 years:		
a. Consulted a physician or any other practitioner, had a check-up, illness, surgery or been hospitalized?	☐ Yes ☐ No	☐ Yes ☐ No
b. Had an electrocardiogram, exercise treadmill test, echocardiogram, X-ray, blood test or other diagnostic test, excluding HIV related tests?	☐ Yes ☐ No	☐ Yes ☐ No
c. Been advised to have, or scheduled, any diagnostic test, hospitalization or surgery which was not completed, excluding HIV related tests?	☐ Yes ☐ No	☐ Yes ☐ No

Non-Medical Questions (Continued)

10. Family History (Complete amount of insurance only if Proposed Insured is under age 17)*
Have any of your immediate family members (parents, brothers and sisters) died or been diagnosed or treated by a member of the medical profession as having diabetes, heart disease, TIA (transient ischemic attack) or other cerebrovascular disorder, cancer, stroke, Huntington's disease and Chorea, neuromuscular disorder, or kidney disease prior to age 60?
PI 1 ☐ Yes ☐ No PI 2 ☐ Yes ☐ No (If Yes, provide details in Medical Impairment section below).

	Age(s) (if living)	Age(s) (at death)	Medical Impairment	Cause of Death	Amount of Insurance*
Father (PI 1)					
Father (PI 2)					
Mother (PI 1)					
Mother (PI 2)					
Brother (PI 1)					
Brother (PI 2)					
Sister (PI 1)					
Sister (PI 2)					

Details for Medical History Questions

Question No. and Letter	Person	Date (mm/dd/yyyy)	Details (include full names and address of physicians, hospitals, etc.)