



Confidential Client Questionnaire - Page 1
Please use with the attached ASG HIPAA Form on Page 4

Agent Information:

Name _____ SS # _____
Address _____ DOB _____
E mail _____
Phone _____ Fax _____ State of Resident License _____

Client Personal History:

Name _____ Male ___ Female ___ DOB _____ SS # _____
Address _____ City _____ State _____ Add State of Res _____
Occupation _____ Earned Income \$ _____ Net Worth \$ _____
Driver License # and State _____ Has client ever received DUI? _____ Year _____

Potential Plan of Insurance:

Plan _____ UL _____ SUL _____ Term _____ WL _____ VUL _____ SVUL _____
Death Benefit _____ Level or Increasing _____ ROP _____ Ultimate DB age 100 _____
State where policy will be written _____ Potential Owner _____
Will Premiums be financed? _____ Purpose of Insurance _____
Will Insurance be replaced? _____ If so what will be replaced _____

Inforce Coverage:

Please provide details of what insurance is currently inforce and what is pending, either as a formal application or informal application

Carrier _____ DB _____ Year Issued _____ Pending _____
Carrier _____ DB _____ Year Issued _____ Pending _____
Carrier _____ DB _____ Year Issued _____ Pending _____

Tobacco / Drug / Alcohol Use:

Has client ever used tobacco in any form _____ Is client currently using tobacco? _____ If so please explain _____
Cigars _____ Cigarettes _____ How Many _____
Alcohol Use - Does client currently use Alcohol _____ Last Time Used _____ How Much _____ Type _____
Drug Use - Has client ever had illegal drug problem? _____ If yes please describe _____
Counseling - Has client ever received AA or other Counseling for Alcohol or Drug Abuse? _____



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Medical History:

Who is the primary care physician _____ Address / Phone _____

Date and reason of last visit _____

Other Physicians/Specialists consulted in last 5 years _____

Date and reason of last visit _____

Hospitalizations (include ER visits) _____

Current Medications _____ Current Height _____ Current Weight _____

Additional Medical Questions:

Has client EVER been treated for any of the following conditions? If "yes" please provide as much detailed information as you can. Feel free to attach an additional sheet if necessary.

Coronary or vascular related illness including High Blood Pressure, Chest Pain, TIA, etc ? _____

Has client EVER had a stress test or other cardiac testing? _____ When? _____ Type of test ? _____

Diabetes _____

Cancer including Skin Cancer _____

Depression or Anxiety Related Disorder _____ Hospitalized? _____

Colitis or Gastro-intestinal related illnesses _____ Last Attack? _____

Family History:

Has any immediate family member including siblings, been diagnosed, or died from heart disease, cancer or diabetes? If yes, please provide full details _____

Relation _____ Diagnosis _____ Age of Disease Onset _____ Age at Death _____

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Foreign Travel:

Is client US Citizen? _____ If not, where is citizenship _____ Is client US resident? ? _____

If client has Visa, what type? _____ Status of Visa _____

Green Card _____ Exp date. _____

Does client expect to travel outside US or Canada for other than vacation or business in the next 2 years? If so, please explain:



Authorization for Release of Health-Related Information
To Agent Support Group
This Authorization Complies With the HIPAA Privacy Rule

Name of Insured/Patient Date of Birth S.S.#

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 protected health information concerning me to Agent Support Group and its agents, employees, and representatives. 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.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without reservation.

This protected health information is to be disclosed under this authorization to that Agent Support Group 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 through Agent Support Group.

This authorization shall remain in force for 30 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 the written request of revocation to Agent Support Group at 99 Park Avenue, New York, NY 10016; 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 the Agent Support Group has 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 redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of, affiliated insurance companies and their reinsurers.

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, Agent Support Group 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.

Empty rectangular box for signature.

Signature of Proposed Insured/Patient of Personal Representative

Date

Empty rectangular box for description of authority or relationship.

Description of Personal Representative's Authority or Relationship to Patient

Companies to which this authorization applies to:

Table listing various insurance companies such as 21st Century, Advanced Settlements, Allianz Life, Allstate Life, American General, American National, ANICO, AVIVA, AVS, AXA Equitable, Bankers Life, Banner Life, Berkshire Life & DI, Case Clearing House, Columbian Life, Companion Life of NY, Coventry First, Credit Suisse, Eastport Capital, Empire General, EMSI, Exam One, First Penn Pacific, Genworth Financial, Genworth Life & Annuity, General American, Goldman Sachs & Co., Guardian, Hartford Life, Hooper Holmes, Indianapolis Life, Integrity Life, John Hancock, Lexnet L. P., Life Settlements, Lifestyle Settlements, Lifemark Partners, Lincoln Benefit Life, Lincoln Life & Annuity, Lincoln Financial Group, Manulife, Manulife Bermuda, Mass Mutual, MedAmerica, Mediconnect, Metropolitan Life, Minnesota Life, Mutual of Omaha, National Integrity, Nationwide, New York Life, Northwestern Mutual, Pacific Life, Parameds.com, Penn Mutual, Phoenix Life, Portamedic, Premium Funding Group, Presidential Life, Principal Life Insurance Co., Principal National Life Insurance Co., Protective Life, Prudential Financial, Reliastar ING, RSA Medical, Scan Tech Solutions, Security Mutual, Sun Life, Transamerica Life Insurance Co., Transamerica Financial Life Insurance Co., Union Central, Universal Life Insurance Group, Universal Underwriters Life Insurance Co., UNUM, US Financial, US Life, USG Annuity, Welcome Funds, West Coast Life, William Penn, Zurich American Life Insurance Co.