



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

Relation Diagnosis Age of Disease Onset Age at Death

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.

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.

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]

Description of Personal Representative's Authority or Relationship to Patient

Companies to which this authorization applies to:

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