



Informal Inquiry

Central Connecticut: 85 River Rd., P.O. Box 227 ~ Collinsville, CT 06022
(860) 693-4999 ~ 1-800-842-8289 ~ FAX (860) 693-4547
In Southern Connecticut: 2563 Main St. ~ Stratford, CT 06615
(203) 386-1500 ~ FAX (203) 375-5733

Life Insurance Brokerage Service

www.thompsonagency.net

| | | | | |
|---|-----------------------------------|---|---|----------------|
| Full Name (print) | | | Plan of Insurance | Amount Desired |
| Date of Birth | Place of Birth | SSN | Additional Benefits Desired (if available) <input type="checkbox"/> Double Indemnity <input type="checkbox"/> Waiver of Premium | |
| Resident Address | | | Beneficiary (Name & Relationship) | |
| <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced | | | Current Life Insurance in Force | |
| Occupation | Company | Amount | Year | |
| Employer | | | | |
| Address | | | | |
| Ever Been | Company | Year | Reason—Table Rating or Extra Premium/Thousand | |
| <input type="checkbox"/> Declined? | | | | |
| <input type="checkbox"/> Rated? | | | | |
| <input type="checkbox"/> EXCLUSIVE - This case is not being shopped other than to my own company. <input type="checkbox"/> SHOPPED—This case is out to other sources by me. <input type="checkbox"/> SHOPPED—This case is out to other sources by another agent. | | | | |
| | Name and Address | Reason | Date | |
| What physician did you last consult? (other than for an insurance examination) | | | | |
| What physicians have you consulted in the last 10 years? | | | | |
| In what hospitals, clinics or sanitariums have you been treated? | | | | |
| Who is your personal physician? When did you last consult him? | | | | |
| Height in Shoes ____ ft. ____ in. | Weight in Shoes _____ lbs. | What medical impairments do you now have? (if diabetic, complete diabetic questionnaire) | Do you use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No A. If "Yes" 1. What do you use? _____ 2. How often or many/day? _____ B. If "No" 1. When did you stop? _____ 2. Did you stop on the advice of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" explain and give name and address of physician. | |
| Submitting Agent Name | | | | |
| Address | | | | |
| Phone (include area code) | | | | |

The Thompson Agency ~ Informal Inquiry

APPLICATION SUPPLEMENT — CORONARY ARTERY DISEASE QUESTIONNAIRE

Name of Proposed Insured :

Date of Birth :

1. Name & Address of cardiologist or other doctor seen most recently for your heart condition: _____ Date of last consultation _____

| 2. Have you had or been told have had: | Most Recent Date | Name of Hospital | Name & Address of doctor consulted. |
|--|------------------|------------------|-------------------------------------|
| Angina Pectoris (heart pain)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Myocardial infarction (heart attack)? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

3. How often do you get heart symptoms (chest, arm or neck discomfort, sense of pressure, etc.)?
 Number of times per month : _____ Number of times per year: _____

4. (a) Date of MOST RECENT treadmill (Stress) electrocardiogram _____ (b) What were you told about the results? Normal Abnormal (c) What doctor or clinic has the results? _____

| 5. Have you had or been advised to have: | | Date | Name & Location of Hospital |
|---|--|------|-----------------------------|
| (a) Cardiac catheterization (coronary angiography)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| (b) Coronary angioplasty (PTCA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| (c) Coronary artery bypass surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

6. How long were you out of work due to conditions in No. 2 and No. 5 above? _____

7. List all medications currently prescribed: _____

8. Do you carry a pill to be placed under the tongue for chest discomfort~ Yes No If "Yes," date last used _____

9. Date of last blood pressure check: _____ Results: _____

10. Date of last cholesterol check: _____ Results: _____

| | |
|---|--|
| <p>11. Do you use tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A. If "Yes"</p> <p>1. What do you use? _____</p> <p>2. How often or many/day? _____</p> <p>B. If "No"</p> <p>1. When did you stop? _____</p> <p>2. Did you stop on the advice of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes" explain and give name and address of physician. _____</p> | <p>12. Do you engage in regular exercise other than that occurring during your work? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes":</p> <p>(a) <u>Type of Exercise</u> <u>No. of Times/Week</u> <u>No. Minutes Each Time</u></p> <p>_____</p> <p>_____</p> <p>(b) How long have you been exercising as above? _____</p> <p>(c) Is this part of a prescribed cardiac rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

13. Family History (a) Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among your parents, brothers or sisters? Yes No (b) Give following information:

| Relationship | Age if Living | Health | Age at Death | Cause of Death |
|----------------------|---------------|--------|--------------|----------------|
| Father | | | | |
| Mother | | | | |
| Brothers and Sisters | | | | |

14. Diet Program

(a) Do you check your weight periodically to detect any change? Yes No Your weight lbs. _____ Height ____ ft. ____ in.

(b) Do you make any planned or supervised adjustments in your eating habits to maintain what you consider to be a desirable weight? Yes No

(c) Have you, within the past three years, followed a controlled diet? Yes No

(1) If "Yes," was it controlled with respect to: Total calories Cholesterol Fats Salt Other

(2) Was information obtained from: Nutritionist Dietician Physician Your reading Structured weight program

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief.
 I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____ 20____

Witness _____ Signature of Proposed Insured _____

The Thompson Agency ~ Informal Inquiry

APPLICATION SUPPLEMENT — APPLICANT'S DIABETIC QUESTIONNAIRE

Supplement to application of _____

Date of birth _____

1. Height _____ ft. _____ in. Weight lbs. _____ Weight two years ago _____ lbs.

2. **When was the diabetes first diagnosed?** Date _____ or your age at time of diagnosis _____

Name and address of physician _____

3. Are you receiving treatment or are you under supervision now? Yes No Date of last visit: _____
Give name and address of physician: _____

4. What is the therapy at present?

A. Diet only _____ B. Insulin _____ Units _____ per day

C. Oral medication (Name) _____

5. When was your last blood sugar test taken? _____ Result? _____

Who performed the test? (Full name and address) _____

6. Do you regularly test your urine or blood for sugar? Yes No Usual results? _____

Date of last test _____

Result of last test _____

7. When was your last glycohemoglobin test? _____ Result? _____

Who performed the test? (Full name and address) _____

8. (a) Have you ever been in diabetic coma? Yes No – Number of times? _____ Dates _____

(b) Have you ever had insulin shock? Yes No – Number of times? _____ Dates _____

(c) If 8(a) and/or 8(b) is answered "Yes," please advise the names of the physicians seen and the hospitals used for the most recent episodes of each.

9. Have you ever had or been told you had any of the following? (Please indicate "Yes" or "No")

Changes in vision or retinopathy _____ Kidney disease _____ Laser therapy _____ Hypertension _____ Skin ulcers _____

Albumin or protein in urine _____ Heart disease* _____ Numbness or neuropathy _____ High cholesterol _____

*If answered "Yes," complete Coronary Artery Disease Questionnaire. Details of any "Yes" answers, including names of physicians and dates

10. Has an electrocardiogram been taken? Yes No If "Yes," give date and by whom

I represent that all statements and answers to the questions above are complete and true to the best of my knowledge and belief. I agree that they form a part of my application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, 20 _____

Witness _____ Signature of Proposed Insured _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization, which is referred to as this form.

INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency

BUREAU: Medical Information Bureau, Inc.

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care services; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organization; (7) financial source; and (8) employer, to give the types of information listed below when this form is presented. A copy of this form is as valid as the original form. I authorize all said sources, except the Bureau, to give such records or knowledge to The Thompson Agency, Inc.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits.

The life insurance companies named below and their reinsurers will use the information in order to determine whether I am insurable. The insurance agent, too, may use this information to help update and improve my insurance program.

Those parties named in the first paragraph of this form may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; (4) other persons who perform business, professional, or insurance tasks for them. They may also disclose this information as may be otherwise allowed by law.

This Authorization will be valid for two years after the date it is signed. I understand that I may ask for a copy of this form.

Signed at _____ this _____ of _____ 200_____

Witness _____ Proposed Insured ✓ _____

American National Life, AXA Equitable, Banner Life, Companion of NY, Genworth Life/Annuity, Genworth Life, Genworth Life of NY, Hartford Life, Indianapolis Life, ING ReliaStar, ING ReliaStar of NY, Lincoln National Life, MetLife Investors USA, MetLife, North American Co., Prudential Financial, Transamerica, United of Omaha, West Coast Life, J&H Copy Service, The Marketing Alliance, The Thompson Agency Inc.



NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others, such as medical professionals who have treated you. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third 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 which appear in the insurance companies' 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 LISTED INSURANCE COMPANIES' AND YOUR AGENT'S INFORMATION PRACTICES IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO:

American National Life, AXA Equitable, Banner Life, Companion of NY, Genworth Life/Annuity, Genworth Life, Genworth Life of NY, Hartford Life, Indianapolis Life, ING ReliaStar, ING ReliaStar of NY, Lincoln National Life, MetLife Investors USA, MetLife, North American Co., Prudential Financial, Transamerica, United of Omaha, West Coast Life, J&H Copy Service, The Marketing Alliance, The Thompson Agency Inc.

NOTICE TO PROPOSED INSURED

In connection with your informal inquiry about 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 inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report Upon written request within a reasonable time after receipt of this notice, detailed information as to the nature and scope of this investigation will be furnished.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life Insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to which a company, the Bureau, upon request, will supply such company with the information It may have In its file.

Upon receipt of request from you, the Bureau will arrange disclosure of any Information It may have in your file. NOTE: (Medical information will be disclosed only to yow attending physician.) If you question the accuracy of information in the Bureau's file. you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the bureau's information office is Post Office Box 105, Essex Station, Boston Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information in their files to other life Insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.