THE THOMPSON AGENCY
Life Insurance Brokerage Service

85 River Road
Collinsville, CT 06019
860.693.4999
800.842.8289
Fax: 860.693.4547

INFORMAL INQUIRY

Full Name (print)			Plan of Insurance	Amount Desired

Date of Birth	Place of Birth	SSN	Additional Benefits Desired (if available) ☐ Double Indemnity ☐ Waiver of Premium

Resident Address	Beneficiary (Name & Relationship)

☐ Male ☐ Widowed	☐ Female ☐ Married	☐ Single ☐ Divorced	Current Life Insurance in Force

Occupation	Company	Amount	Year
Employer			
Address			

Ever Been	Company		Year	Reason—Table Rating or Extra Premium/Thousand		
☐ Declined?						
☐ Rated?						

☐ EXCLUSIVE - This case is not being shopped other than to my own company. ☐ SHOPPED—This case is out to other sources byme.
☐ 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	Weight in Shoes	What medical impairments do you now have? (if diabetic, complete diabetic questionnaire)
____ft. ____in.	_____lbs.	

Submitting Agent Name

Address

Phone (include area code)

Do you use tobacco in any form?
☐ Yes ☐ 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? ☐ Yes ☐ No

If "Yes" explain and give name and address of physician.

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RISK QUESTIONNAIRES

Please visit our website at:

http://www.thompsonagency.net/Impaired-Risk-Life-Insurance-Questionnaires.html

Choose and complete the relevant Impaired Risk Questionnaire(s) for your case and submit the completed forms along with your completed Informal Inquiry.

The following Questionnaires are available on the site:

Abnormal EKG
Alcohol Use
Angioplasty
Aortic Regurgitation
Aortic Stenosis
Arthritis
Asthma
Aviation
AvocationBladder Cancer
Breast Cancer
Bundle Branch Block
Cardiomyopathy
Cervical Cancer
Cholesterol
Colits & Crohn's Disease
Colorectal Cancer
Congestive Heart Failure
COPD
Depression
Diabetes
Drug Use
Epilepsy & Seizure
Foreign Travel & Residence
General Cancer
General Medical
Glomerulonephritis
Heart Attack
Heart Disease
Hematuria
Hemchromatosis
Hepatitis
Hodgkin's Disease
Hypertension
Informal Inquiry
Irregular Heart Beat
Kidney Disease
Kidney Stone
Leukemia Cancer
Liver Enzyme Elevation
Lupus
Mitral Valve Prolapse
Mitral Valve Regurgitatioon
Mitral Valve Stenosis
Multiple Sclerosis
Ovarian Cancer
Pacemaker
Parkinson's Disease
Peridarditis
Polycystic Kidney Disease
Prostate Cancer
Protenuria
PSA Elevation
Quick Quote Form
Renal Insufficiency
Sarcoidosis
Skin Cancer
Sleep Apnea

THE THOMPSON AGENCY
Life • Long Term Care • Disability • Annuity
BROKERAGE SERVICE

Authorization to Access Medical Information by General Agent or Broker / TA HIPAA Authorization

I, _____
(Print name of proposed Insured)

hereby authorize The Thompson Agency, Inc. of Connecticut, their employees, officers, affiliates, (collectively, "The Thompson Agency") access to any and all medical information ("Information"), which has been collected in connection with my current request for life insurance. Information includes but is not limited to the results of any physical examination or tests, electrocardiogram, chest X-ray and Attending Physician Statements.

It is my understanding that the purpose of this authorization is to facilitate submission of this Information by the General Agent or Broker or their authorized representatives to other insurers to evaluate an application for insurance on my life. I understand that The Thompson Agency assumes no liability with respect to any application for insurance and makes no representation as to the completeness or accuracy of the Information. I also understand that The Thompson Agency will only provide disclosures as permitted by law, and, in its sole discretion, may not provide all Information in its possession. It is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

This authorization is effective as of the date it is signed and shall continue for six (6) months unless otherwise provided by law. I also understand that I may revoke this authorization by providing written notification to The Thompson Agency at The Thompson Agency, Inc. 85 River Road, Collinsville, CT 06019, which revocation shall be subject to the rights of The Thompson Agency to the extent The Thompson Agency has acted in reliance on the authorization prior to notice of revocation. A copy of this authorization shall be as valid as the original.

HIPAA Authorization

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 _____20_____

Witness/Agent Signature _____

Signature of Proposed Insured_____

American General Life Companies, US Life, American National Life, AXA Equitable, Banner Life, Cincinnati Life, Columbus Life, Companion of NY, Genworth Life/Annuity, Genworth Life, Genworth Life of NY, Lincoln National Life, Mass Mutual, MetLife Investors USA, MetLife, Minnesota Life, North American Co., OneAmerica, Pacific Life, Prudential Financial, Protective Life, SBLI of MA, Centrian Life, Symetra, Transamerica, United of Omaha, William Penn Life, J&H Copy Service, Express Imaging Svc., Jetstream APS, The Marketing Alliance, The Thompson Agency Inc.