

RISK FINDER

Preliminary Inquiries - Not an Application for Life Insurance

This risk finder form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Personal History (This Section Must be Completed)

Name:	Sex:	Date of Birth:	
Social Security #:	Age:	Height:	Weight:
Address		Phone:	
City:	State:	Zip:	
Monthly Income:			
Occupation:	Industry:	Position:	
Tobacco/Nicotine Usage:			
1. Have you ever smoked cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last usage:			
2. Have you ever used other tobacco or nicotine containing products (ex. cigars, pipe, snuff, nicotine gum or patch)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last usage:			

Agent Information (This Section Must be Completed)

Name:	Social Security #:		
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	

Requested Plan of Insurance (This Section Must be Completed)

Minimum Premium Consideration: \$5,000	
Universal Life, Variable Life, Whole Life Term, Level Period:	
Survivorship*, Disability Income, Monthly Benefit Amount:	
Face Amount Desired:	
Premium Amount Desired:	Annually/Monthly:
What will be the Purpose of the Insurance?	

*Please have other proposed insured submit Risk Finder as well.

Provide Details on Pending and In Force Coverage

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do You Intend to Replace?

All pages of the Risk Finder must be completed. Inquiry cannot be considered unless authorization is signed on pages 4 and 5 by proposed insured.

RISK FINDER

Proposed Insured:

Social Security #:

Medical History (This Section Must be Completed)

Who is your Primary Care Physician?

Doctor's Address: _____ Doctor's Phone Number: _____

Date of last visit and reason:

List all current medications:

Additional Physicians/Facilities - Hospitals consulted in the past 5 years:

1) Date and reason for visit:

Doctor's Name: _____

Doctor's Address: _____ Doctor's Phone Number: _____

Facility/Hospital and Location: _____

Treatment and Findings: _____

2) Date and reason for visit:

Doctor's Name: _____

Doctor's Address: _____ Doctor's Phone Number: _____

Facility/Hospital and Location: _____

Treatment and Findings: _____

Family History

Check here if this section is not applicable

Have any immediate family members (parents/siblings) been diagnosed or died from heart disease or cancer? Yes No

If yes, please provide the following details:

Relation	Diagnosis	Approximate Age at Disease Onset	Age at Death (if deceased)

Drug and Alcohol Usage Questionnaire

Check here if this section is not applicable

Do you currently drink alcohol? Yes No

Did you ever drink substantially more than presently? Yes No

Date of last consumption: _____ If yes, when? _____

Note Amount Below: _____ Note Amount Below: _____

	Amount Per Week		Amount Per Week
Beer <input type="checkbox"/>		Beer <input type="checkbox"/>	
Wine <input type="checkbox"/>		Wine <input type="checkbox"/>	
Liquor <input type="checkbox"/>		Liquor <input type="checkbox"/>	

Have you ever consulted a doctor or received treatment because of your alcohol use? Yes No

Have you ever been arrested for driving under the influence of alcohol? Yes No

If yes, provide date(s): _____

Have you ever sought medical treatment because of drug use or has drug use ever been a problem? Yes No

If yes, provide details: _____

Type of drug(s) used: _____ Date of last use: _____

2 All pages of the Risk Finder must be completed. Inquiry cannot be considered unless authorization is signed on pages 4 and 5 by proposed insured.

RISK FINDER

Proposed Insured:

Social Security #:

Coronary		
Check here if this section is not applicable <input type="checkbox"/>		
Date of diagnosis of first chest pain:	Number of diseased vessels:	
Dates/details of treatment/surgery (<i>ex. angioplasty, bypass</i>):		
Date of last EKG:	Results:	By whom:
Any pain since treatment/surgery:		

Cancer		
Check here if this section is not applicable <input type="checkbox"/>		
Exact name and location of cancer:		
Stage and grade:		
Who would have the pathology report?:		
Dates/details of treatment/surgery:		

Diabetes		
Check here if this section is not applicable <input type="checkbox"/>		
Date of diagnosis:		
Treatment:	<input type="checkbox"/> Diet only <input type="checkbox"/> Oral Medication <input type="checkbox"/> Insulin	Details:
Do you regularly test your blood glucose?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Results:
Latest result of glycohemoglobin (A1C) test:	mg%	Date:
Have you ever been diagnosed with having protein and/or microalbumin in your urine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had any of the following:		
<input type="checkbox"/> Eye trouble	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Trouble	<input type="checkbox"/> Neuritis/Neuralgia	<input type="checkbox"/> Insulin Reactions

Hazardous Activities		
Check here if this section is not applicable <input type="checkbox"/>		
Are you a private pilot? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details:	
How many total hours have you flown as Pilot in Command?	How many hours do you fly per year:	
Do you have an IFR (instrument flight rating)? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what?	
Do you participate in the following activities (check all that apply)?		
<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Ultra Flying	<input type="checkbox"/> Mountain Climbing <input type="checkbox"/> Hang Gliding
<input type="checkbox"/> Sky Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Auto/Motorcycle Racing

Authorization

This authorization is HIPAA compliant

Purpose

The purpose of this Authorization is to permit First American Insurance Underwriters, Inc. to obtain and release nonpublic personal information about me, the Proposed Insured named below, for the purpose of determining my eligibility for and obtaining insurance products and services for one or more of the insurers or other institutions (“the Companies”) listed on the reverse of this document pursuant to this Authorization shall include any and all information, to the extent permitted by applicable law.

Information to be Released

The information to be released pursuant to this Authorization includes any personal health information, records or data concerning my past, present or future mental, physical or behavioral health or conditions (“Information”), to the extent permitted by law. Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits. I understand that this Information may include results from blood, saliva, urine and other tests. I further understand that this Information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical test results.

Authorization

I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, Pharmacy Benefits Manager, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such Information to First American Insurance Underwriters, Inc., and its authorized representatives. I specifically authorize the Companies listed on the reverse of this document to receive Information from and to release Information to First American Insurance Underwriters, Inc. I also specifically authorize First American Insurance Underwriters, Inc. and the Companies listed on the reverse of this document to release Information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (“MIB”) to release Information directly to any Company listed on the reverse of this document, upon such insurer’s request, provided the insurer is a member of MIB. *I understand that Information disclosed to First American Insurance Underwriters, Inc. may have been subject to state and federal privacy laws and regulations. I understand that in some circumstances the information authorized to be disclosed to First American Insurance Underwriters, Inc., may be re-disclosed to individuals or entities that are not subject to health information privacy laws, in such case my medical information may no longer be protected by federal health information privacy laws. I understand that if I refuse to sign this Authorization to release my complete medical records, First American Insurance Underwriters, Inc. or the Companies listed on the reverse of this document may not be able to process my request. I also authorize my Agent, named below, to receive Information and I authorize First American Insurance Underwriters, Inc. to disclose such Information to my Agent to assist in the purpose of this Authorization to the extent permitted by law. A photocopy of this Authorization shall be as valid as the original. This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of revocation is provided to First American Insurance Underwriters, Inc. at 460 Hillside Avenue, Needham, MA 02494. Any action taken in reliance on this Authorization prior to the notice of the revocation shall be valid.

Proposed Insured’s Signature (or that of Authorized Representative)

Date

Print Name of Proposed Insured

If signed by Authorized Representative of Proposed describe authority, e.g. parent or guardian of minor child.

Print Name of Agent

A Copy of the Notification Appearing Below Must be Given to the Proposed Insured Before or At the Time of Signature.

In the course of properly underwriting, administering and evaluating your insurance coverage, the listed companies will rely heavily on information provided by you. The companies may also seek information from others such as medical professions who have treated you. In some situations, and in compliance with applicable law, the 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 a copy, if you wish, of items of personal information about you which appear in the insurance companies' files. You also have the right to seek correction of information you believe to be inaccurate.

Allianz	Guarantee Trust Life	North American
Allstate	Hartford	Ohio National
American General	ING-Reliastar	Phoenix Life
American National	John Hancock	Presidential Life
Assurity Life	Legal & General America	Principal Life Insurance Company
Aviva	(Banner/William Penn)	Principal National Life Insurance Company
AXA Equitable	Life Insurance Company of the Southwest	Protective Life
Bankers	Lincoln Benefit	Prudential
Boston Mutual	Lincoln Financial	Sagicor
Cincinnati Life	MetLife	SBLI
Columbian Life	Minnesota Life	Transamerica
Companion	Mutual of Omaha	Union Central
Fidelity	National Life of Vermont	United Home Life
Foresters	Nationwide	United States Life
Genworth	New York Life	Zurich

For underwriting and claims purposes, I permit:

Any physician or other medical practitioner, hospital, clinic or other medically related facility to give the companies listed above data of a medical nature. This data includes findings on medical care, psychiatric or psychological care and examination, or surgery. I specifically authorize the disclosure to the companies listed above any information, or surgery. I specifically authorize the disclosure to the companies listed above any information concerning sexually transmitted diseases including venereal diseases, any Human Immunodeficiency Virus (HIV) test results, or information about Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, or confidential HIV related information, and any information concerning a serious communicable disease, use of drugs or alcohol and any information concerning mental health.

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 THESE PRACTICES, PLEASE SEND YOUR REQUEST TO FIRST AMERICAN INSURANCE UNDERWRITERS, INC.

Proposed Insured's Signature

Date

Print Name

Date

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB, as part of our underwriting process, we or one of the insurance companies listed on page six may request an investigative consumer report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or other with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is normally conducted, but you are entitled to make a specific request. We keep such information reports confidential and use them only to evaluate and underwrite your application. You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is good reason to do so. We take steps to make our computer database secure and to safeguard the information we have. We may disclose personal information about you without prior authorization under certain circumstances. For example, we may disclose information about you to persons or organizations to allow such persons or organizations to perform a business, professional or insurance for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. We may give information to accounting firms performing audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interest. Information may be disclosed to reinsurance companies or other insurance company to which you have applied for coverage or benefits. Information may be furnished your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law. We may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which you may not be aware or to persons or organizations for the purpose of conducting research, including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured's lives. No medical record information or personal information relating to your character, personal habits, mode of living or general reputation will be released to anyone who receives personal information for the purpose of marketing a product or service.

You Can Review and Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit). Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside First American Insurance Underwriters, Inc.

If you want to know more about our privacy policy, please contact us at First American Insurance Underwriters, Inc., 460 Hillside Avenue, Needham, MA 02494.

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask it to correct the information as provided in the Federal Fair Trade Act. You can write to MIB, Inc., Post Office Box 105, Essex Station, Boston, MA 02112 or call 617.426.3660.

All pages of the Risk Finder must be completed. Inquiry cannot be considered unless authorization is signed on pages 4 and 5 by proposed insured.