JURS MONTGOMERY BROKERAGE LLC

INFORMAL APPLICATION

Client Information:

Name:	Date of Birth:	Sex: ☐ Male ☐ Female	Height:_____ Weight_____
Resident Address:		City:	State: / Zip:
Have you ever used tobacco products? ☐ Yes ☐ No	If yes, describe type, frequency and date last used:		
Are you a U.S. Citizen? ☐ Yes ☐ No	If no, please include details:		
Insurance Requested: ☐ Whole Life ☐ Universal Life ☐ Term (If term, length desired_____)		Face Amount Desired:	Premium Desired:
Purpose of Insurance:		Occupation:	Monthly Earned Income:

Agent Information:

Name:	Agent Phone:	Agent Fax:	Agent Email:
Business Address:		City:	State: / Zip:

Pending and Inforce Coverage:

Carrier:	Policy Number:	Face Amount:	Rate Class:	Will you be replacing? ☐ Yes ☐ No
Carrier:	Policy Number:	Face Amount:	Rate Class:	Will you be replacing? ☐ Yes ☐ No
Carrier:	Policy Number:	Face Amount:	Rate Class:	Will you be replacing? ☐ Yes ☐ No
Carrier:	Policy Number:	Face Amount:	Rate Class:	Will you be replacing? ☐ Yes ☐ No

Medical History(Please include all physicians seen in the past 10 years):

Doctor's Name:	Date of last visit:
Address:	Phone:
Reason/Dates/Treatments:	
Doctor's Name:	Date of last visit:
Address:	Phone:
Reason/Dates/Treatments:	
Doctor's Name:	Date of last visit:
Address:	Phone:
Reason/Dates/Treatments:	

Please attach any additional physicians or hospitals on a separate page.

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Medications Prescribed:

Family History:

Relation(mother, father, brother, sister):	Diagnosis:	Age of onset:	Age at death:

Cancer:

Type and location of cancer:
Stage and grade:
Physician(s) who treated:
Dates/details of treatment:

Coronary:

Date of Diagnosis:	Number of diseased vessels:
Physician(s) who treated:	
Dates/details of treatment:	
Follow up details:	

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Diabetes:

Date of diagnosis:	Treatment: ☐ Diet Only ☐ Oral Medication ☐ Insulin	Details:
Do you regularly test your blood glucose? ☐ Yes ☐ No	Results:	Frequency:
Date of last glycohemoglobin (A1C) test:	Results:	
Have you ever been diagnosed with having protein or micro albumin in your urine? ☐ Yes ☐ No		

Have you ever had:	Any eye trouble?	☐ Yes	☐ No	Kidney trouble?	☐ Yes	☐ No
	High blood pressure?	☐ Yes	☐ No	Heart trouble?	☐ Yes	☐ No
	Insulin reactions?	☐ Yes	☐ No	Neuritis/neuralgia?	☐ Yes	☐ No

Alcohol and Substance Abuse:

Do you current drink alcohol? ☐ Yes ☐ No	Did you ever drink substantially more than present? ☐ Yes ☐ No	If yes, when?
Note Amount Per Week:	Note Amount Per Week:	
Beer:	Beer:	
Wine:	Wine:	
Liquor:	Liquor:	
Have you ever used illegal drugs? ☐ Yes ☐ No		If yes, type(s) of drugs and frequency:
Have you ever been arrested for driving under the influence of drugs or alcohol? ☐ Yes ☐ No		If yes provide date(s):
Have you ever consulted a doctor or been treated for alcohol or drug abuse? ☐ Yes ☐ No		If yes, date of last of treatment:
Please provide details:		
Date of last usage:		

Avocation(Please check all that apply):

If yes, please complete appropriate questionnaire:

☐ Private Pilot	☐ Scuba Diving
☐ Sky Diving	☐ Auto/Motorcycle Racing
☐ Bungee Jumping	☐ Hang Gliding
☐ Mountain Climbing	☐ Other:

Authorization for Disclosure – HIPAA Compliant

Give completed and signed copy to Proposed Insured
(This authorization complies with the HIPAA Privacy Rule)

Proposed Insured/Patient (please print)_____DOB_____SS#_____

I authorize Jurs Montgomery Brokerage, LLC, the agent/broker named below, Insurance support organizations (such as MIB, Inc), the companies listed at the bottom and their reinsures; agent's employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other Insurance coverage, or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to the individuals/entities named above. 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 My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization a my request, as permitted by 164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate 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 with the Company(s).

This authorization shall remain in force for 24 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 a written request for revocation to Jurs Montgomery Brokerage, LLC. Alternately, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extend that any of My Providers have relied on this authorization or the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule). I authorize by my signature below that photocopy or facsimile may be regarded as original.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

Signature:_____ Date:_____
Proposed Insured/Patient or Personal Representative

If authorization has been signed by a personal representative of the proposed insured/patient, please describe the basics for the personal representative's authority to act on behalf of the proposed insured/patient:_____

Agent/Broker_____Signature_____Date_____

Companies to Which This Authorization Applies:

AIG/American General Life/Accordia Life and Annuity Company/Allianz/Allstate Life of NY/American National/AXA Equitable/Banner Life/Bankers Life of NY/Berkshire/Boston Mutual/Columbus Life/Companion Life of NY/Coventry First/Empire General/EMSI/Exam One/Fidelity Security/First Penn/Genworth Life and Annuity Insurance Company/Genworth Life Insurance Company of New York/General American/Guarantee Trust Life/Guardian Life/Hartford Life/ ING Reliastar/ING Reliastar of NY/ING Companies/Jefferson Pilot/John Hancock/Liberty Life/Life Exams/Lincoln Benefit Life/Lincoln Financial/Lincoln Life of NY/Manulife/Mass Mutual/MetLife/Minnesota Life/MONY/Nationwide/New York Life/North American Life/Old Mutual Financial Network/Pacific Life/Penn Mutual/Phoenix Life/Portamedic/Presidential Life/Principal Insurance Company/Principal National Insurance Company/Protective Life/Prudential/Pruco Life of NJ/SBLI/Security CT/Security Life of Denver/Security Mutual/Standard/State Life/SunLife/SunLife of NY/Symetra/TransAmerica/Travelers/ UNIFI Companies/Union Central/United of Omaha/UNUM/US Financial/US Life/Valley Forge/West Coast Life/William Penn/Zurich