Informal Inquiry

This is not an Application for Insurance

RAMPART AGENCY
INSURANCE SERVICES

Agent's Name: _____ Email Address: _____

Phone Number: _____ Fax Number: _____

Proposed Insured : _____ Sex: ☐ Male ☐ Female

SSN: _____-_____-_____ Date of Birth: _____ Place of Birth: _____

Resident State: _____ Amount of Insurance Desired: _____

Plan of Insurance: ☐ Whole Life ☐ Universal Life ☐ Term _____ yrs. ☐ Second To Die ☐ Long Term Care ☐ Disability Insurance

Have you smoked cigarettes in the past 12 months? ☐ Yes ☐ No Have you smoked cigarettes in the past 36 months? ☐ Yes ☐ No

Do you use any other form of Tobacco products such as the Patch, Gum, Chewing Tobacco, Cigar, etc? ☐ Yes ☐ No

If Yes, Describe Use: _____

How Much Insurance Inforce Now? $_____

Has Case Been Submitted to Other Companies in the Past 6 Months? ☐ Yes ☐ No *(If yes, list Companies & Dates Submitted)*

LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED

Name of Company	Face Amount	Year	Issued? Yes/No	Extra Premium or Rating	Reason Rated or Declined

PHYSICIAN / HOSPITAL INFORMATION

	Name, Address, Phone Number	Reason	Date
What Physician did you last consult? (Other than insurance examination)			
What Physicians have you consulted during the past 10 years?			
In what hospitals, sanitariums or clinics have you ever been treated?			

AUTHORIZATION FOR RELEASE OF HEALTH RELATED INFORMATION. THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE.

I authorize _____ to give any information about me or my mental or physical health to the Company and/or its authorized agents to determine my eligibility for insurance and/or benefit payment. The information authorized for release includes my entire medical record, excluding psychotherapy notes, but including any information regarding medications used, drug and alcohol treatment, and communicable or venereal diseases, such as, hepatitis, syphilis, gonorrhea, the human immunodeficiency virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It also includes motor vehicle records. For purposes of this Authorization, I hereby revoke any prior restriction on disclosure of my medical records, and authorize the release of my entire medical records to the Company, excluding psychotherapy notes. This Authorization may be revoked at any time by writing to us at the address listed above. The revocation will not be valid to the extent we relied on the Authorization to contest coverage. Revocation or alteration of this Authorization may mean that we will not be able to complete the application process and may deny a claim for insurance. The Company may retain and disclose information to the Medical Information Bureau, reinsurers, or for insurance underwriting, policyholder service or claim handling, to others who perform services for us, or as otherwise allowed by law. Any revocation of this authorization will not impact these rights of disclosure. Once disclosed to the Company, the information will no longer be protected by the by the Health Insurance Portability and Accountability Act, but will be protected by other applicable federal and state laws relating to the protection of personal information. This Authorization also applies to any member of my family proposed for coverage in the application and is valid for two years after the date below. A copy of this Authorization will be provided to me by my insurance representative or the Company, either at the time of execution or shortly thereafter. I understand my representative can tell me how and when I will receive a copy. A photocopy of this Authorization is as valid as the original. I have read and agreed to all the applicable terms of this form. I also understand this form in its entirety will be provided to the individual listed in the Authorization above in order to request medical information to determine eligibility for coverage.

_____ _____

Signature of Primary Proposed Insured Date
(If age 15 or over, otherwise applicant)

AIG/American General	Banner Life	Genworth Life Ins. Co.	John Hancock of NY	Minnesota Life Ins. Co.	Principal National Life Ins. Co.	Savings Bank Life Ins. Co. of MA	United of Omaha
Allstate Life of NY	Companion Life of NY	ING Reliastar	John Hancock USA	Mutual of Omaha	MedAmerica	Security Mutual Life	US Life of New York
American National	Fidelity Life	ING Reliastar of NY	Lincoln Benefit Life	Nationwide—Provident Mutual	Metlife Investors	Standard Insurance Company	West Coast Life
Assurity	Fidelity Security	ING Security Life of Denver	Lincoln Life & Annuity Co. NY	New York Life	Protective Life	The Hartford	William Penn of NY
AVIVA	Genworth Life and Annuity	Integrity Life	Lincoln National	North American	Protective Life of NY	Transamerica Life Ins. Co.	
AXA Equitable	Genworth Life Ins. Co. of NY	John Hancock Life	MassMutual	Principal Life Ins. Co.	Prudential	UNIFI Companies	

One Parker Plaza–Suite 1105
Fort Lee, NJ 07024
Phone: (800) 221-4623 * Fax: (201) 585-1811

2005 South Easton Road–Suite 202
Doylestown, PA 18901
Phone: (800) 491-7100 * Fax: (267) 880-0656

1983 Marcus Avenue–Suite C130
Lake Success, NY 11042
Phone: (516) 390-3800 * Fax: (516) 390-3565

CHEST PAIN QUESTIONNAIRE

Date of first Episode of chest pain : _____

Name of physician first consulted for chest pain: _____

Name of physician now giving treatment or medical supervision: _____

Has electrocardiogram been made? ◻ Yes ◻ No

Date : _____

By Whom? _____

Was it normal? _____

Has chest X-ray been made? ◻ Yes ◻ No

Date : _____

By Whom? _____

Was it normal? _____

Have you ever had or been treated for:

A.	**Chest pain?**	◻ Yes	◻ No
B.	**Skipping of heart?**	◻ Yes	◻ No
C.	**Shortness of breath?**	◻ Yes	◻ No
D.	**High blood pressure?**	◻ Yes	◻ No

Was the pain brought on by:

A.	**Exertion?**	◻ Yes	◻ No
B.	**Exercise?**	◻ Yes	◻ No
C.	**Excitement?**	◻ Yes	◻ No
D.	**Strain?**	◻ Yes	◻ No

Where was pain located:

A.	**Middle of Chest?**	◻ Yes	◻ No
B.	**Left side of Chest?**	◻ Yes	◻ No
C.	**Left shoulder, arm or hand?**	◻ Yes	◻ No
D.	**Both shoulders or arms?**	◻ Yes	◻ No
E.	**Stomach?**	◻ Yes	◻ No

Did you have:

A.	**Sense of pressure/constriction?**	◻ Yes	◻ No
B.	**Sweating?**	◻ Yes	◻ No
	Was hospital care required?	◻ Yes	◻ No
	Have you had more than 1 episdoe?	◻ Yes	◻ No

Give number, dates, freq. & date of last episode in REMARKS section.

Are you now, or have you been, on medication such as digitalis, peritrate, nitroglycerin, vasodilators, blood pressure medicine, etc? ◻ Yes ◻ No

Do you carry a pill to be placed under the tongue for chest discomfort? ◻ Yes ◻ No

DIABETES QUESTIONNAIRE

Date of diabetes diagnosis: _____ Name of physician first consulted for diagnosis: _____

Name of physician now giving treatment or medical supervision: _____

What treatment do you use?

Diet only? ◻ Yes ◻ No

Insulin? ◻ Yes ◻ No **Name:** _____ **# of units:** _____

Oral Medication? ◻ Yes ◻ No **Name :** _____ **# of tablets:** _____

Do you regularly test your urine for sugar? ◻ Yes ◻ No Results (please check): ◻ Usually Negative ◻ Usually a trace ◻ Usually more than a trace

Date of last test : _____ Result of last test : _____

Have you had any blood sugar tests? ◻ Yes ◻ No Date: _____ ◻ Fasting ◻ Non-Fasting ◻ A1C Result: _____

Have you ever been treated for: Insulin Reactions? ◻ Yes ◻ No Diabetic Coma? ◻ Yes ◻ No *(Give dates, physician & hospital in REMARKS section)*

Have you ever had: *Give dates, physician & hospital in REMARKS section)*

A.	**Any eye trouble?**	◻ Yes	◻ No
B.	**Heart trouble?**	◻ Yes	◻ No
C.	**High blood pressure?**	◻ Yes	◻ No
D.	**Kidney Trouble (albuminuria, etc.)?**	◻ Yes	◻ No
E.	**Neuritis or neuralgia**	◻ Yes	◻ No

Has weight changed in past year?	◻ Yes	◻ No
Weight 1 year ago	_____	**lbs**
Present weight	_____	**lbs**
Present height	_____	

Has anyone in your immediate family (parents, brothers & sisters) died before the age of 65 or been diagnosed before 65 with coronary heart disease, stroke, cancer or kidney disease? ◻ Yes ◻ No

FAMILY HISTORY	Age Living	Age Deceased	Present Health or Cause of Death
Father			
Mother			
Brothers			
Sisters			

REMARKS: