RAMPART AGENCY INSURANCE SERVICES | HILB GROUP

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULES

Patient Name: Date of Birth: Click or tap here to enter text.

SSN:

Name, Address & Phone Number	Reason for Treatment	Date of Last Visit
Primary Care Physician		
All other physicians or hospitals providing treatment in the past 10 years		

This authorization is for the Release of Health-Related Information to The Hilb Group of NY, LLC dba Rampart Agency

My Providers are any health plan physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, pharmacy benefits manager or other health care provider that has provided payment, treatment or services to me or on my behalf. This includes psychotherapy care. My Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; the use of alcohol, drugs, and tobacco; and psychotherapy notes.

I authorize my Providers to disclose my Protected Health Information to the above-named company or person(s); their agents, employees, representatives, and providing facilities.

By signing below: 1) I acknowledge that any agreements I make that restrict my Protected Health Information do not apply to this authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the above named may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4) administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the above named. This authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by doing so in writing and presenting the written revocation to the above named. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to an insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer protected 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.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my Protected Health Information, the above named may not be able to assist me in processing my application.

I acknowledge that I have received a copy of this Authorization.

SIGNATURE OF PROPOSED INSURED *(If age 15 or over, otherwise applicant)*

DATE

AUTHORIZED INSURANCE CARRIERS				
AIG	EQUITABLE	MUTUAL OF OMAHA	PRINCIPAL NATIONAL LIFE	THE STANDARD
ALLIANZ	FIDELITY SECURITY - DI	NATIONAL GUARDIAN LIFE	PROTECTIVE LIFE	TRANSAMERICA LIFE
AMERICAN NATIONAL	GLOBAL ATLANTIC	NATIONAL LIFE	PROTECTIVE LIFE OF NY	UNITED OF OMAHA
AMERITAS	JOHN HANCOCK	NATIONWIDE	PRUDENTIAL	US LIFE OF NY
ASSURITY	JOHN HANCOCK OF NY	NEW YORK LIFE	RAMPART LIFE	WILLIAM PENN OF NY
BANNER	LINCOLN NATIONAL LIFE	NORTH AMERICAN	SBLI	ZURICH
CENTURIAN	LINCOLN LIFE & ANNUITY OF NY	ONE AMERICA	SECURIAN	
CINCINNATI LIFE	LLOYDS OF LONDON	PACIFIC LIFE	SECURITY MUTUAL LIFE	
COLUMBUS LIFE	MINNESOTA LIFE	PRINCIPAL LIFE	SYMETRA	

Informal Inquiry

This is not an Application for Insurance

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages.
(If additional space is needed, use page 6 or add a separate page).

Complete, accurate information produces the most competitive carrier offers
Because of the significant expense involved in purchasing medical records, our underwriting staff has final discretion regarding pre-purchase of client's medical records.

If submitting for informal Survivorship quotes, please complete a separate application for each proposed insured and submit together.

SECTION 1: Broker/Advisor Information

Agent's Name:_____ Firm/Agency: _____

Email Address:_____ Phone Number:_____ Fax Number: _____

SECTION 2: Case Design Information

☐ Single Life Case ☐ Survivorship (complete 2 apps) ☐ First To Die (complete 2 apps) ☐ Long Term Care ☐ Disability Insurance

Plan of Insurance: ☐ Whole Life ☐ Universal Life ☐ Term _____yrs. ☐ Second To Die ☐ LTC ☐ Other_____

Amount of Insurance Desired:_____ If no lapse - carry guarantees to age:_____

Riders: _ _____

Premium Design (i.e. lump sum, 1035, limited pay): _____

Purpose of Coverage (i.e. estate plan, buy-sell, etc.): _____

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	Date	Issued? Yes/No	Extra Premium or Rating	Reason Rated or Declined

SECTION 3: Proposed Insured Information

Proposed Insured :_____ Sex: ☐ Male ☐ Female
Last Name First Name MI

SSN: _____-_____-_____ Date of Birth: _____Place of Birth: _____

Drivers License No:_____ State of Issue: _____

Residence Address: _____
Street City State Zip Code

Employer: _____ Position: _____

Duties:_____ Years at Current Job: _____

Annual Income:_____ Net Worth:_____

If additional room is needed for any subsection, please use Page 6

SECTION 4: Existing Insurance

INFORCE INSURANCE

Name of Company	Face Amount	Year Issued	Purpose	Keeping or Replacing

SECTION 5: Foreign Travel/Citizenship

US Citizen? ☐ Yes ☐ No How Long?_____ Yrs. If No, Country of Citizenship:_____Dual Citizenship? ☐ Yes ☐ No

Have you traveled outside North America or Western Europe in the last 2 years or intend to do so in the next 2 years? ☐ Yes ☐ No

If yes, list dates traveled (or anticipated traveling dates), country and purpose of trip on Page 6

SECTION 6: Medical Information

Height:_____ Weight:_____ Any change greater than 10 pounds in the last 2 years? ☐ Yes ☐ No

If yes, please explain: _____

MEDICATIONS—PLEASE LIST ANY PRESCRIPTION AND NON-PRESCRIPTION MEDICATIONS BELOW *(if more room is necessary please list on Page 6)*

Medication	Dosage	Date Started	Purpose	Prescribing Doctor's Name	Results of Use

SECTION 7: Lifestyle & Avocation Information

SUBSECTION A: Aviation

Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years?

☐ Yes ☐ No If yes, hours flown last year?_____Anticipated hours next 12 months_____

License type: _____Date of last flight:_____ Aircraft type & purpose: _____

SUBSECTION B: Scuba/Skin Diving

Have you engaged in or plan to engage in scuba or skin diving? ☐ Yes ☐ No

If yes, number of dives last year?_____ Anticipated dives next 12 months_____Maximum Depth_____

Where do you dive?: (i.e. rivers, open ocean, etc.) _____

Purpose of diving?: (i.e. vacation, commercial, instructor) _____

If additional room is needed for any subsection, please use Page 6

SUBSECTION C: Motor Vehicle/Boat Racing

Have you engaged or do you plan to engage in any type of motor vehicle or boat racing? ☐ Yes ☐ No

If yes, please provide details on license type, circuit, frequency, etc. below or on Page 6 if necessary

Notes: _____

SUBSECTION D: Scuba/Skin Diving

Have you engaged in or plan to engage in any mountain climbing, sky diving or other hazardous sports activities? ☐ Yes ☐ No

If yes, please provide details below or on Page 6 if necessary

Notes: _____

SUBSECTION E: Convictions/Bankruptcy

Have you declared bankruptcy or been convicted of a felony offense in the last 10 years? ☐ Yes ☐ No

If yes, please provide details below or on Page 6 if necessary

Notes: _____

SUBSECTION F: Driving Record

Have you had any moving violations or had your license restricted or revoked in the last 10 years? ☐ Yes ☐ No

If yes, please provide details and dates below or on Page 6 if necessary

Notes: _____

SUBSECTION G: Tobacco/Alcohol Usage

Do you use any tobacco or nicotine products currently? ☐ Yes ☐ No

Type	Amount per day	How many years	Plan to quit Y/N

Have you use ever used tobacco or nicotine products in any form? ☐ Yes ☐ No

☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe ☐ Snuff ☐ Other _____

Type	Amount per day	Date Last Used

Do you consume alcohol? ☐ Yes ☐ No

Type	Quantity	Frequency

Have you ever been treated for or recommended to seek treatment for alcohol abuse? ☐ Yes ☐ No

Notes: _____

SUBSECTION H: Drug Usage

Do you consume drugs other than prescribed by a physician? ☐ Yes ☐ No

Notes: _____

Have you ever been treated for or recommended to seek treatment for drug abuse? ☐ Yes ☐ No

Notes: _____

SUBSECTION I: Excercise

Do you exercise regularly? ☐ Yes ☐ No

Type of Exercise	Number of Times Per Week	Duration

Notes:

_ _____

SUBSECTION J: Diet

Do you manage your diet? ☐ Yes ☐ No

Do you check your weight periodically to detect any changes? ☐ Yes ☐ No

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

Notes: _____

Have you, within the past 3 years, followed a controlled diet? ☐ Yes ☐ No

If "Yes", was it controlled with respect to: ☐ Total Calories ☐ Cholesterol ☐ Fats ☐ Salt ☐ Other_____

Was dietary information obtained from: ☐ Nutritionist ☐ Dietician ☐ Physician ☐ Your Own Reading ☐ Structured Weight Program

Time Period of Controlled Diet: _____

SUBSECTION K: Family History

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

Notes: _____

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

SECTION 8: Medical Care Providers Information

Primary Care Physician

Name:_____ Phone Number: _____Fax Number:_____

Address: (Street)_____(City)_____(State)_____(Zip)_____

Date/Purpose and Results of Last Visit:

Notes: _____

Specialist or Other Care Provider

Name:_____ Phone Number: _____Fax Number:_____ Address:

(Street)_____(City)_____(State)_____(Zip)_____

Date/Purpose and Results of Last Visit:

Notes: _____

Specialist or Other Care Provider

Name:_____ Phone Number: _____Fax Number:_____

Address: (Street)_____(City)_____(State)_____(Zip)

Date/Purpose and Results of Last Visit:

Notes: _____

SECTION 9: Medical Questions *(If you answer "YES" to any of these questions, please provide additional details on Page 6)*

Within the last 10 years–have you had symptoms of, or been told by a physician that you have had or have:

Part 1			
A.	**Chest pain?**	◻ Yes	◻ No
B.	**Skipping of heart?**	◻ Yes	◻ No
C.	**Shortness of breath?**	◻ Yes	◻ No
D.	**High blood pressure?**	◻ Yes	◻ No
E:	**Heart murmur?**	◻ Yes	◻ No
F:	**Stroke (TIA)?**	◻ Yes	◻ No
G:	**Irregular Heartbeat?**	◻ Yes	◻ No
H:	**Other Disease or Disorder of the Heart or Arteries?**	◻ Yes	◻ No

Part 2			
A.	**Diabetes?**	◻ Yes	◻ No
B.	**Elevated Blood Sugar?**	◻ Yes	◻ No
C.	**Glucose Intolerance?**	◻ Yes	◻ No
D.	**Disease of any Glands?**	◻ Yes	◻ No

Part 3			
A.	**Asthma?**	◻ Yes	◻ No
B.	**Bronchitis?**	◻ Yes	◻ No
C.	**Pneumonia?**	◻ Yes	◻ No
D:	**Emphysema?**	◻ Yes	◻ No
E.	**Any Other Lung Disoder?**	◻ Yes	◻ No

Part 4			
A.	**Mental/Emotional Disorder?**	◻ Yes	◻ No
B.	**Nervous Breakdown?**	◻ Yes	◻ No
C.	**Convulsions?**	◻ Yes	◻ No
D.	**Epilepsy?**	◻ Yes	◻ No
E:	**Paralysis?**	◻ Yes	◻ No
F:	**Other Disorder of the Brain or Nervous System?**	◻ Yes	◻ No

Part 5			
A.	**Arthritis?**	◻ Yes	◻ No
B.	**Gout?**	◻ Yes	◻ No
C.	**Other Bone, Joint, Muscle or Skin Disorder?**	◻ Yes	◻ No

Part 6			
A.	**Anemia?**	◻ Yes	◻ No
B.	**Leukemia?**	◻ Yes	◻ No
C.	**Clotting Disorders?**	◻ Yes	◻ No
D.	**Platelet Disorders?**	◻ Yes	◻ No
E.	**Infections?**	◻ Yes	◻ No
F.	**Other Source of Blood Loss?**	◻ Yes	◻ No

Part 7			
A.	**Cirrhosis?**	◻ Yes	◻ No
B.	**Hepatitis?**	◻ Yes	◻ No
C.	**Ulcers?**	◻ Yes	◻ No
D.	**Colitis?**	◻ Yes	◻ No
E:	**Diverticulitis?**	◻ Yes	◻ No
F:	**Ileitis?**	◻ Yes	◻ No
G:	**Other Disease of the Liver, Gall Bladder, Pancreas, Stomach or Intestines**	◻ Yes	◻ No

Part 8			
A.	**Prostate/Testicular Disease?**	◻ Yes	◻ No
B.	**Disease of the Uterus, Ovaries or Breasts?**	◻ Yes	◻ No

Part 9			
A.	**Kidney or Uniary Tract Disorder?**	◻ Yes	◻ No
B.	**Sugar, Albumin or Blood in the Urine?**	◻ Yes	◻ No

Part 10			
A.	**Cancer or Tumors of Any Kind (Malignant or Benign)?**	◻ Yes	◻ No

If there are any other health impairments or medically treated conditions not mentioned above or you have been advised to seek treatment for any impairment or condition that has not been treated please provide details on Page 6

General and Medical Question Responses/Details

Please provide the question number and details as appropriate. For Medical questions, Please provide as much detail as possible regarding diagnosis, onset date, duration of condition, treatments, current status and caregiver/ provider with contact information.

Section/Question	Dates	Details