IMPAIRED RISK QUESTIONNAIRE PACKET

NOTE: Please attach copies of whatever is available (i.e. exams, EKGs, lab results, APSs, etc.)

Date: ______________________ Agent: ______________________

Full Legal Name: ______________________ US Citizen? ☐ Yes ☐ No

Maiden Name: ______________________ Known by any other name: ______________________

Date of Birth: ______________________ Birth State: ______________________

Social Security #: ______________________ Driver's License # / State: ______________________

Height: ____ ft. ____ in. Weight: ______________________ Marital Status: ______________________

Annual Income: $______________________ Approx. Net Worth: ______________________

Requested Plan of Insurance

Type: ☐ Term ☐ Permanent Individual ☐ Permanent Survivorship (other insured needs to complete Confidential Inquiry Request too)

Face amount desired: $______________

What will be the purpose of the insurance?

Misc. Comments (i.e. certain carriers to send inquiry to):

Pending and in-force coverage ☐ **None in-force or pending**

Have you ever been declined by an insurance carrier? ☐ NO ☐ YES

Has any other insurance been applied for within the last three months on yourself? ☐ NO ☐ YES

If yes, provide details (i.e. Carrier sent to? Currently being looked at by reinsurers? Is there a formal or informal offer on the table?)

Company	Policy/App Date	Amount	Class/Rating Issued	Premium	Replace?
					Y / N
					Y / N
					Y / N
					Y / N

Do you currently use ***tobacco products****?* ☐ NO ☐ YES (see questions below)

If yes, check all that apply: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chewing Tobacco ☐ Patch/Gum

Quantity: ______________________ How often: ______________________

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IMPAIRED RISK QUESTIONNAIRE PACKET

Family History	If living, current age(s)	If not living, age at death	State of health or cause and date of death
Father			
Mother			
Brothers			
Sisters			

Is there any history of diabetes, cancer or heart disease in parents or siblings?

☐ NO ☐ YES If yes, please give details.

Within the last two years have you ever participated in any vehicle racing on land or water, bobsledding, scuba or skin diving, skydiving or parachuting, ultralight aviation, or mountaineering?

☐ NO ☐ YES - If yes, please include details:

Have you had your driver's license restricted or revoked, or been charged with three or more moving violations?

☐ NO ☐ YES If yes, provide details.

Have you been convicted of a felony within the last five years?

☐ NO ☐ YES If yes, provide details.

Travel

Do you contemplate residence or travel outside of the United States within the next year?

☐ NO ☐ YES If yes, for business, vacation, or residence? Where? Timing? How long?

Alcoholic Beverages

Do you use alcoholic beverages? ☐ NO ☐ YES If yes, type, how often and quantity?

MEDICAL INFORMATION

(Complete if a medical exam will not be done at this time.)

In the past 10 years, have you ever had any indication of:		**Yes**	**No**
1.	Chest pain, high blood pressure, heart disease, heart murmur or other disorders of the heart or blood vessels?		
2.	Ulcers, colitis, jaundice, or other disease of the stomach, liver, intestines, gallbladder, kidney or urinary bladder?		
3.	Seizures, fainting, dizziness, epilepsy, stroke or paralysis?		
4.	Any nervous, mental, or emotional disorder, or received counseling for anxiety, depression, stress or any other emotional condition?		
5.	Any tumor, cancer, cysts or any disorder of the lymph nodes?		
6.	Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones or joints? Do you use any adaptive devices such as a wheelchair, walker or cane?		
7.	Diabetes, thyroid, or other endocrine or glandular disorder?		
8.	Anemia or any other blood disorder?		
9.	Asthma, emphysema, shortness of breath, sleep apnea or any other disorder of the respiratory system?		
10.	Any disorder of the eyes, ears, nose or throat?		
11.	Any complication of pregnancy or disorder of the reproductive organs (testicles, prostate, breasts, ovaries, uterus, cervix, etc)?		
12.	Any allergy or skin disorder?		
13.	Any mental or physical disorder not listed above?		
14.	In the past five years, have you been a patient in a hospital, clinic, sanatorium or other medical facility, or been advised to have any hospitalization or surgery which has not been completed?		
15.	Are you now under the treatment or care of a health care practitioner for any reason?		
16.	In the past 10 years, have you ever been treated for drug use or dependency or alcohol abuse?		

Details of “yes” answers: Identify question number, circle applicable items. Include diagnosis, dates, duration and names of addresses of all attending physicians and medical facilities.

DOCTOR INFORMATION SURVEY

All Doctor Information for the Past five Years
(This is very important so that we obtain all medical evidence for the underwriters review.)

Primary Doctor: ____

Address: ____

Phone: (   ) __________________ Date last consulted: ________________

Reason seen and results: ____

Medications: ____

____

Primary Doctor: ____

Address: ____

Phone: (   ) __________________ Date last consulted: ________________

Reason seen and results: ____

____

Medications: ____

____

Primary Doctor: ____

Address: ____

Phone: (   ) __________________ Date last consulted: ________________

Reason seen and results: ____

____

Medications: ____

____

In the last year have you completed any of the following?

☐ Treadmill EKG ☐ Resting EKG ☐ Chest X-Ray

Date: __________________ Doctor: ________________________

Authorization to Start Medical Underwriting (Without Obligation)

THE FAIR CREDIT REPORT ACT NOTIFICATION

In compliance with Public Law 90-508 (Fair Credit Reporting Act), I understand that as a part of the underwriting procedure, any life insurance company listed below may secure on me a routine inquiry involving interviews with third p arties such as family members, business associates, financial sources, friends, or others who may have information concerning my character, general reputation, personal characteristics, and mode of living. I further understand that upon written request from me, additional information will be provided concerning the nature and scope of such inquiry if one is made.

EXCHANGE OF INFORMATION (MEDICAL INFORMATION BUREAU)

The underwriting process (evaluation of risk) is necessary not only to assure that you pay a reasonable cost for your insurance, but also to assure that each policyholder contributes his or her fair share of the cost. In considering your application, information from various sources must therefore be considered. These may include the results of your physical examination and any reports we may receive from doctors and hospitals who have attended you. The information regarding your insurability will be treated as confidential. Any one of the life insurance companies listed below, or their reinsurers, may however, make a brief report thereon to the Medical Information Bureau, Inc. (MIB) a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information it may have on file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file (medical information will be disclosed only to your attending physician). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. MIB's information office is Post Office Box 105, Essex Station, Boston MA 02112. MIB's telephone number is (617) 426-3660. If you would like to receive a more detailed explanation of our procedures and your rights, please send your request to: The Life Operations Manager at Asset Marketing Systems.

AUTHORIZATION TO OBTAIN INFORMATION BY

Allianz	**Bankers Life of NY**	**John Hancock USA**	**Mutual of Omaha/United of Omaha**	**Sagicor**
American General (AIG)	**Banner**	**Lafayette Life**	**North American (NACOLAH)**	**Savings Bank (SBLI)**
American National	**Fidelity Life**	**LSW**	**Old Mutual (OMFN)**	**West Coast Life**
Assurity Life	**Foresters**	**Lincoln Benefit**	**Protective Life**	
Aviva Life and Annuity	**Genworth Life (GLIC/GLAIC)**	**Lincoln Financial (LFG)**	**Prudential**	**Other Life Settlement Companies**
AXA - Equitable	**ING/Reliastar/Security Life of Denver**	**Met Life Investors**	**RBC/Liberty Life**	

I HEREBY AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, the Medical Information Bureau, Inc. consumer report agency, employer, or other person having records or knowledge of me or my family's physical or mental health, or any other information bearing on my insurability, or any insurance support organization to give Asset Marketing Systems and any insurance or life settlement company listed above, or its legal representative any and all the information it holds that pertains to medical consultations, treatments and prognosis, surgeries, and hospital confinements as concerning the physical and mental condition of myself. This authorization shall include all information about my medical history, diagnosis, treatment and prognosis including information regarding alcoholism or drug abuse and any other non-health (non-medical) history information.

I UNDERSTAND that the information obtained by use of this Authorization will be used by Asset Marketing Systems, its agents, and any insurance or life settlement company, to determine my eligibility for life insurance coverage, or eligibility for benefits under an existing policy. Any information obtained will not be released by any insurance companies listed above to any persons or organizations performing business or legal services in connection with my application, claim, or as my otherwise be lawfully required or as I my further authorize.

I KNOW that I may receive a copy of this Authorization at my request, and I AGREE that a photographic copy of this Authorization shall be valid as the original.

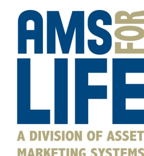
I AGREE that this Authorization shall be valid for 30 months from the date shown below.

I VOLUNTARILY consent to the withdrawal of blood from me by needle, the testing of my blood for HIV antibodies. All test results will be treated confidentially. The results will be reported to the insurers named above, and may be reported to affiliates, reinsurers, or contracts in connection with insurance I have or have applied for. In addition, if my HIV antibody test is positive, a generic code signifying a non-specific blood abnormality may be made known to the MIB. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by me. The results of a positive test will be sent to me at the address provided, by registered mail with delivery restricted only to me.

SIGNATURE (ONE SIGNATURE PER FORM) DATE

AUTHORIZATION

The purpose of MIB is to protect its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. Information furnished by MIB may alert the insurer to the possible need for further investigation, but under MIB rules, cannot be used as the basis for evaluating risk. MIB is not a repository for medical reports from hospitals and physicians and information in the MIB file does not reveal wither applications for insurance are accepted, rated, or declined.



9715 Businesspark Avenue
San Diego, CA 92131
Phone: (866) 546-5267
Fax: (858) 348-0814
www.amsforlife.com