

**Preliminary Inquiry Form and HIPAA Authorization  
NOT AN APPLICATION FOR LIFE INSURANCE**

**Instructions to Agent**

- This is a medical release packet, NOT AN APPLICATION FOR INSURANCE.
- If your client has not been DECLINED by FBL, you will need management approval to write a formal application with another company!
- Please email the completed forms to [matt@lifeagents.com](mailto:matt@lifeagents.com) or fax them to 407-706-0347
- The minimum face amount for full underwriting is \$100,000. Guaranteed issue is available in some states. If your client has a limited premium tolerance, please call Creekmore Insurance Group to discuss hypotheticals to see if there is a potential market before submitting this inquiry paperwork.
- If you have received a “verbal decline” and did not submit a formal application to FBL, please call Creekmore Insurance Group to discuss hypotheticals BEFORE completing this paperwork.
- Completed inquiry paperwork must be signed by the client and returned to Creekmore **BEFORE** you discuss any client case specifics with Creekmore.
- No illustrations will be sent to the agent until completed and signed preliminary inquiry paperwork is received by Creekmore.
- Additional information, answers to frequently asked questions, and medical questionnaires for 140+ common conditions are available online at [www.LifeAgents.com/FBFS](http://www.LifeAgents.com/FBFS).

**Agent Information**

Name _____	Phone _____	Fax _____
Address _____ City _____ State _____ Zip _____		
Email Address _____		

**Requested Plan of Insurance**

<input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Term ____ years <input type="checkbox"/> SUL* <input type="checkbox"/> DI <input type="checkbox"/> LTC            *For SUL complete one form on each client		
Face amount \$ _____ Premium desired \$ _____		

**Please list any adverse actions or table ratings offered by other companies:**

Company	Date	Action / Rating	Face Amount	Premium
<b>FARM BUREAU</b>				

**Case Background Information**

Total life insurance in force _____		Date of application(s) _____	
Is a replacement intended? <input type="checkbox"/> Yes <input type="checkbox"/> No    Company _____    Premium _____			
Cigarette smoker? <input type="checkbox"/> Yes <input type="checkbox"/> No    Any other nicotine use? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date and type: _____			
Height and weight: _____ Annual Income _____ Occupation _____			
Any other comments : _____			

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**CLIENT INFORMATION**

Client Name: \_\_\_\_\_ Gender:  M /  F  
SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Annual Income \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider ("My Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to the companies referenced on this authorization ("the Companies") and its agents, employees and representatives. 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 or that of my unemancipated minor children 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 at my request, as permitted by SS 164.508(c) (1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

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 the Company(ies) at 365 Aulin Ave., Oviedo, FL 32762, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that nay of My Providers has relied on this Authorization or to the extent that the Company(ies) has 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 the HIPAA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance wit other applicable state and/or federal privacy laws and its own privacy policy.

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 or that of my unemancipated minor children, the Company(ies) may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization. A photocopy of this form is as valid as the original. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc. to give such records or knowledge to Creekmore Insurance Group, Inc. By signing below, I agree to the terms of this authorization.

I understand that the life insurance companies named below, their reinsures, any insurance support organizations, and the authorized representatives of those companies may need to collect information on me in regard to proposed coverage. Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc. consumer reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy.

The types of information will include records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal traits. The information will be used by the insurance companies named below and their reinsures to determine eligibility of insurance, claims and/or by the Insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or any other persons or organizations performing business, professional, or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_

Prospective Insured's Name (please print): \_\_\_\_\_

Signature of Prospective Insured X \_\_\_\_\_

- |                                 |                                |                           |                              |                                  |
|---------------------------------|--------------------------------|---------------------------|------------------------------|----------------------------------|
| Allianz Life                    | Farm Bureau Life / FBFS        | John Hancock              | Farm Bureau Financial Svcs   | Prudential                       |
| AIG American General Life       | Fidelity & Guaranty Life       | Kansas City Life          | MONY                         | Standard Insurance               |
| American National               | First Penn Pacific             | Life Investors            | Mutual of Omaha              | Sun Life of Canada               |
| Aviva Life Insurance Company    | Genworth                       | Lincoln Benefit           | New York Life (NYL)          | Transamerica                     |
| AXA Equitable Life              | Great American                 | Lincoln National          | North American Co. L&H       | United of Omaha                  |
| Banner Life                     | Guardian                       | Lloyds of London          | Old Mutual Financial Network | United States Life               |
| Boston Mutual                   | Hartford Life                  | Mass Mutual               | Pacific Life                 | Western Reserve Life             |
| Canada Life Annuity             | Indianapolis Life              | MedAmerica                | Penn Mutual                  | West Coast Life /Protective Life |
| Columbus Life                   | Insurance Intermediaries, Inc. | MetLife / New England     | Phoenix Life                 | Advanced Settlements             |
| Creekmore Insurance Group, Inc. | ING / Reliastar                | Minnesota Life            | Presidential Life            | Coventry                         |
| Equitrust                       | Jefferson Pilot                | Farm Bureau Life Ins. Co. | Principal Life               | Trinity Financial, LLC           |

