

**INFORMAL INSURABILITY INQUIRY**  
**PLEASE COMPLETE ALL QUESTIONS IN FULL**

cmgca.com

IF DIABETIC OR CARDIAC CASE, PLEASE COMPLETE APPROPRIATE FORM ON REVERSE SIDE.

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FULL NAME (PRINT)		PLAN OF INSURANCE <input type="checkbox"/> ADB <input type="checkbox"/> WP	AMOUNT DESIRED \$
DATE OF BIRTH	PLACE OF BIRTH	BENEFICIARY (Name & Relationship)	
RESIDENT ADDRESS		HOW MUCH INSURANCE IN FORCE NOW?	
MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		HEIGHT: ____ FT. ____ INCHES    WEIGHT: ____ LBS.	
OCCUPATION _____		Has case been submitted to other companies in past 6 months?    Yes <input type="checkbox"/> No <input type="checkbox"/>	
EMPLOYER _____		If yes, list companies, dates submitted, and other.	
ADDRESS _____			

**FAMILY HISTORY (Important)**

Relation	Age if Living	State of Health or Cause of Death	Age at Death
Father			
Mother			
Brothers &			
Sisters			

**LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:**

Name of Company	Amount	Year	Declined?	Issued?	Extra Premium	Reason Rated or Declined

NAME, ADDRESS, TELEPHONE #	REASON	DATE
What physician did you last consult? (Other than insurance examination)		
What physicians have you consulted during the past 10 years?		
In what hospital, clinic, or sanitarium have you ever been treated?		
Who is your personal physician? When did you last consult him?		

HAVE YOU USED ANY TOBACCO PRODUCTS IN THE PAST 12 MONTHS?     YES     NO  
 What kind and how much? \_\_\_\_\_

IS THIS INQUIRY TO REPLACE EXISTING COVERAGE?     YES     NO

REMARKS: \_\_\_\_\_  
 Agent \_\_\_\_\_ Address \_\_\_\_\_  
 Telephone No. (    ) \_\_\_\_\_

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Life Insurance Companies listed on this form at the time of my signature any such information. A photographic copy of this authorization shall be valid as the original.

We represent:

American General	Great American	Old Republic	Southland Life
Boston Mutual	Guarantee Trust Life	Peoples Benefit Life	State Life
Fidelity & Guaranty	Jefferson-Pilot	Reliance Life	U.S. Financial
First Penn-Pacific	Old Line Life	Security-Connecticut	

I have received the Notice of Exchange and Fair Credits Act.

Veterans Administration Case No. \_\_\_\_\_

C- \_\_\_\_\_ Date \_\_\_\_\_ Proposed Insured MUST Read Authorization and Sign

INSTRUCTIONS TO AGENT: The notice below must be detached and given to the Proposed Insured before or at the time of signature.

**NOTICE OF EXCHANGE OF INFORMATION**

The information regarding your insurability will be treated as confidential. However, the Life Insurance Companies listed on this form at the time of my signature may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange for its members. If you apply for life or health insurance to another company which is also a member of the Bureau or if a claim for benefits is submitted to such a company, the Bureau will, upon request, supply the information in its file to that company. The Life Insurance Companies listed on this form at the time of my signature may also release information in its file, including information given your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. Upon receipt of a request from you, the Medical Information Bureau 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 the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex-Station, Boston, Massachusetts 02112.

**FAIR CREDIT REPORTING ACT NOTICE**

The Life Insurance Companies listed on this form at the time of my signature may secure personal interviews with third parties such as family members, business associates, financial source, friends, or others with whom you are acquainted with concerning your character, general reputation, personal reputation, personal characteristics and mode of living. Upon written request, additional information will be provided as to the nature and scope of the report, if one is made.

We represent:

All American Life	Great American	Metropolitan	Southland Life
American General	Great Southern	Old Line Life	Southwestern Life
Boston Mutual	Guarantee Trust Life	Old Republic	State Life
Commonwealth Life	Jefferson-Pilot	Prudential	U.S. Financial
First Penn-Pacific		Security-Connecticut	