AMG
brokerage general agency

Affiliated Marketing Group
4800 Sugar Grove Blvd., Suite 350
Stafford, Texas 77477
713.977.0611
life@affiliatedmarketing.com

Date:

Authorization Form

Personal History (required information)

Name:	Sex: ☐ M ☐ F	Soc. Sec. #:	
Address:	City:	State:	Zip:
Telephone:	Date of Birth:	Height:	Weight:
Occupation:	Monthly Earned Income:	Net Worth:	
DL#:	State:	Email:	

Tobacco / Nicotine Usage

1. Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, date of last usage:
2. Have you ever used other tobacco or nicotine products? ☐ Yes ☐ No
   If yes, provide types and last date of use:

Agent Information (required)

Name:	Soc. Sec. #:		
Address:	City:	State	Zip
Telephone:	Fax:		
E-mail:			

Requested Plan of Insurance (required)

☐ Universal Life ☐ Variable Life ☐ Whole Life ☐ Term, Level Period ☐ Survivorship

Face amount desired:	Max. premium commitment:

1035 exchange or dump in? How much?

What will be the purpose of insurance?
**Please have other proposed insured submit Informal App as well.*

Provide details on pending and in-force coverage:

Company	Policy/App date	Amount	Class/Rating Issued	Current Premium	Replacing?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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Proposed Insured: **Soc. Sec. #:**

Medical History (required information)

Who is your primary care physician? Doctor's name, address, phone #. When did you last consult her/him?	**Date**	**Illness**
What other physicians have you consulted within the last 5 years? (Do not include insurance examinations)		
In what hospitals, clinics or other health facilities have you been treated?		

Please list all current medications: Name	Dosage	Frequency	Reason for taking

Drug and Alcohol Questionnaire (required)

Do you currently drink alcohol? ☐ Yes ☐ No
Date of last consumption:
Note amount below:

Did you ever drink substantially more than present? ☐ Yes ☐ No
If yes, when?
Note amount below:

Type	Amount per week	Type	Amount per week

Have you ever consulted a doctor or received a treatment because of your alcohol use? ☐ Yes ☐ No
Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No
If yes, please provide date(s):

Have you ever sought medical treatment because of drug use or has drug use ever been a problem? ☐ Yes ☐ No
If yes, please provide details:
Types of drug(s) used:
Date of last use:

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Coronary (☐ check here if this section is not applicable)

1. Date of diagnosis or first chest pain:
2. Number of diseased vessels:
3. Dates/details of treatment/surgery (i.e., Angioplasty, Bypass, etc.):

4. Date of last stress EKG:
   Results:
   By whom:
5. Any pain since treatment/surgery?

Cancer (☐ check here if this section is not applicable)

1. Exact name and location of cancer:
2. Stage and grade:
3. Who would have the pathology report?
4. Dates/details of treatment/surgery:

Diabetes (☐ check here if this section is not applicable)

1. Date of diagnosis:
2. Treatment: (mark one) ☐ Diet only ☐ Oral Medication ☐ Insulin
   Details:
3. Do you regularly test your blood glucose? ☐ Yes ☐ No
   Results: Frequency:
4. Have you ever been diagnosed with having protein and/or microalbumin in your urine? ☐ Yes ☐ No
5. Have you ever had:
   a. Any eye trouble? ☐ Yes ☐ No
   b. Heart trouble? ☐ Yes ☐ No
   c. High blood pressure? ☐ Yes ☐ No
   d. Kidney trouble? ☐ Yes ☐ No
   e. Neuritis/neuralgia? ☐ Yes ☐ No
   f. Insulin reactions? ☐ Yes ☐ No

Other health details:

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Proposed Insured: **Soc. Sec. #:**

Medical Check-ups				
Procedures	**Date of last test**	**Check-ups often?**	**Results normal?**	**If particularly good, any reason why? (i.e., diet)**
Blood Pressure check-up			☐ Yes ☐ No	
Cholesterol screen			☐ Yes ☐ No	
Electrocardiogram (EKG) – resting			☐ Yes ☐ No	
Electrocardiogram (EKG) – stress			☐ Yes ☐ No	
Chest X-Ray			☐ Yes ☐ No	
Sigmoidoscopy			☐ Yes ☐ No	
Mammogram (women)			☐ Yes ☐ No	
Prostate exam (men)			☐ Yes ☐ No	
Other			☐ Yes ☐ No	

Nutritional Supplements			
Name of supplement	**Dates used**	**Quantity taken**	**Frequency taken**
Multi-vitamin / Mineral supplements			
Special dosage of Vitamin E			
Special dosage of Folic Acid			
Aspirin: ☐ Regular ☐ Baby			
Other			

Lifestyle Variables	
Describe your exercise program	
Sports you engage in regularly	
Describe your alcohol / tobacco usage	
Are you actively at work full time?	
Other favorable lifestyle habits	

Family History					
	Age	**Age of death**	**Cause of death if deceased**	**History of heart disease or circulatory disorder**	**History of cancer (all types)**
Mother				☐ Yes ☐ No	☐ Yes ☐ No
Father				☐ Yes ☐ No	☐ Yes ☐ No
Sister(s)				☐ Yes ☐ No	☐ Yes ☐ No
Brother(s)				☐ Yes ☐ No	☐ Yes ☐ No

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REQUIRED – DOCTOR INFORMATION

Along with your life insurance application, the company you are applying with requires us to order copies of your doctor's records. This includes your primary care physician along with any specialists or other doctor's you may have seen. Please be as detailed as possible as to the name, address and phone number of your doctors. Incomplete information can cause significant delays and will result in a lengthy processing time.

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

Doctor: Phone:
Address:
Current Medications:
Last Visit:
Reason:

You may want to call your doctor to give them a head's up that you are applying for life insurance and that we will be requesting an APS (Attending Physician Statement) from them. This may give some time for them to prepare your paperwork and have it ready.

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Voice 713.977.0611

I hereby authorize Affiliated Marketing Group and _____("my Representative") and it's staff, affiliated companies including Pinney Insurance and/or entities, insurance companies and their re-insurers, to possess, obtain and/or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long term care or other insurance products.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This include 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 terminate any agreements I have made with my Providers to restrict my medical records and associated HIPAA protected health information and I instruct my providers to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of Affiliated Marketing Group, affiliated insurance companies and their re-insurers.

AIG, American General Life Insurance Company, American National Insurance Companies, Assurity Life Insurance Company, AXA Life, Insurance Company, Banner Life Insurance Company, Companion Life Insurance Company, The Coventry Group, Credit Suisse Group, Genworth Financial Family of Companies, AVIVA & Affiliates, A.I. Credit Corp., HSBC, ING USA Annuity and Life Insurance Company, John Hancock, Liberty Life Insurance Company, Lifestyle Settlements, Lincoln Benefit Life, Lincoln National Life Insurance Company and their affiliates, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, North American Company for Life and Health Insurance, Old Mutual Financial Life Insurance Company, Pacific Life Insurance, Peachtree Settlement Funding, Principal Life Insurance Company, Protective Life Insurance, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Savings Bank Life Insurance-SBLI, Security Life of Denver Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, West Coast Life Insurance Company

The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that my action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured's Name _____

Proposed Insured's Signature _____

Agent / Witness _____

Signed and Dated on _____ At _____(City and State)