MA OFFICE
389 Boston Post Road
Sudbury, MA 01776-3015
978-443-4900 (Local)
800-443-4922 (Outside MA)
978-443-9804 (Fax)

The Marcus Agency
Superior Service Since 1960

PA OFFICE
P.O. Box 148
Fort Washington, PA 19034
215-793-9440 (Local)
877-793-9440 (Outside PA)
215-793-9441 (Fax)

INFORMAL INQUIRY

This is not an Application for Insurance

Full Name (Print) | Sex | Plan of Insurance | Amount Desired

$

Date of Birth / / | Place of Birth | Social Security Number - -

Physical Address | Amount of Existing In-Force Coverage

$

Do you use tobacco of any form? **Yes or No** If yes, what type?: _____ Height: _____ft._____in. Weight: _____lbs.

Occupation: _____ Employer: _____

Address: _____

Beneficiary (Name & Relationship): _____

Why are you applying on an informal basis?: _____

LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:

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

	NAME & ADDRESS	REASON	DATE
What Physician did you last consult? (Other than insurance examination)			
What Physicians have you consulted during the past 10 years?			
In what hospitals, clinics, or sanitariums have you ever been treated?			
Who is your personal Physician? When did you last consult him?			

AGENT'S NAME _____ AGENT'S PHONE NUMBER _____

AGENT'S ADDRESS _____

www.themarcusagency.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The Marcus Insurance Agency, Inc. and its staff, affiliated companies and/or entities, including but not limited to RSA Medical, 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, including but not limited to RSA Medical, insurance companies and their re-insurers. 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, my prescription records and history of medication prescribed, but excludes psychotherapy notes.

By my signature below, I terminate any agreements I have made with my Providers to restrict my medical records and any 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 a 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 The Marcus Insurance Agency, Inc. affiliated insurance companies and their re-insurers. 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 any 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, State, Zip Code)

American General · Allianz Life · American National · Aviva · AXA Equitable · Banner Life · Companion Life · Fidelity Life · Fidelity and Guaranty · Genworth Life & Annuity · Genworth Life of New York · ING · John Hancock · Lincoln Benefit Life · Lincoln Financial · Metropolitan Life · Mutual of Omaha · Nationwide · Petersen International · Principal · Protective · Prudential · ReliaStar Life · ReliaStar Life of New York · Security Life of Denver · Transamerica · Union Central · United of Omaha · U.S. Life of New York · William Penn