

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



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 _____

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize The Marcus Insurance Agency, Inc. (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

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 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 the Representative and its staff, affiliated companies and/or entities, 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, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure 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 insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

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 the Representative to revoke this authorization and that the revocation will take effect when the 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 also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured's Name

Proposed Insured's Signature

Signed and Dated On

At (City, State, Zip Code)

Agent/Witness Name

Print Agent/Witness Signature

AIG • Allianz Life Insurance Company of North America • American General Life Insurance Company • American National Insurance Companies • Assurity Life • AXA Equitable Life Insurance Company • Brighthouse Financial • Banner Life Insurance Company (Legal and General) • Cincinnati Insurance Companies • Companion Life Insurance Company • Fidelity Life Association • Fidelity and Guaranty Life Insurance Company • Genworth Financial Family of Companies • Global Atlantic Financial Group • John Hancock • Lincoln National Life Insurance Company • Mass Mutual • Minnesota Life Insurance Company • Mutual of Omaha Insurance Companies • National Guardian Life • Nationwide Life Insurance Company • Nationwide Life and Annuity Insurance Company • New York Life • One America Financial Partners • Pacific Life Insurance • Petersen International Underwriters • Principal National Life Insurance Company • Principal Life Insurance Company • Protective Life Corporation • Prudential Insurance Company of America • SBLI • Securian Life Insurance Company • Security Mutual • Symetra Life Insurance Company • Transamerica Insurance & Investment Group • The Standard • 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 • Zurich North America Insurance Company