

**American Financial Network, LLC**  
**14 Walsh Dr., Suite 201, Parsippany, NJ 07054**  
**Tel 973-263-0054 Fax 973-263-0043**

## INFORMAL INQUIRY FORM

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

|  |                   |                         |                            |                |
|--|-------------------|-------------------------|----------------------------|----------------|
| <b>Name</b> <small>(last, first, M.I.)</small> | <b>Telephone:</b> | <b>DOB:</b>             | <b>Height:</b>             | <b>Weight:</b> |
| <b>Address:</b>                                |                   | <b>City, State, ZIP</b> |                            |                |
| <b>Primary Doctor:</b>                         |                   | <b>Telephone:</b>       | <b>Date of last visit:</b> |                |
| <b>Address:</b>                                |                   | <b>City, State, ZIP</b> |                            |                |
| <b>List of Specialists:</b>                    |                   |                         |                            |                |
| <b>Doctor's Name:</b>                          |                   | <b>Specialty</b>        | <b>Telephone:</b>          |                |
| <b>Doctor's Name:</b>                          |                   | <b>Specialty</b>        | <b>Telephone:</b>          |                |

### PERSONAL HEALTH HISTORY

|   |  |
|---|--|
| <p>Please check the boxes below for all those that apply</p> <p><b>1. Have ever been treated for or had any indication of:</b></p> <p><input type="checkbox"/> a. Disorder of the eyes, ears, nose or throat?</p> <p><input type="checkbox"/> b. Dizziness, fainting, convulsions, headache, speech defect, Paralysis, or stroke, mental or nervous disorder?</p> <p><input type="checkbox"/> c. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic respiratory disorder?</p> <p><input type="checkbox"/> d. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the heart or blood vessels?</p> <p><input type="checkbox"/> e. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder?</p> <p><input type="checkbox"/> f. Sugar, albumin, blood or pus in the urine, venereal disease, nephritis, stone, and or disorder of the kidney, bladder, prostate or reproductive organs?</p> <p><input type="checkbox"/> g. Diabetes, thyroid, or other endocrine disorder?</p> <p><input type="checkbox"/> h. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones?</p> <p><input type="checkbox"/> i. Deformity, lameness, or amputation?</p> <p><input type="checkbox"/> j. Disorder of skin, lymph glands, cyst, tumor, or cancer? k. Allergies, anemia, or other disorder of the blood?</p> <p><b>2. In the past 10 years have you:</b></p> <p><input type="checkbox"/> a. Had or been told you have or received treatment or advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related complex (ARC) or AIDS related conditions?</p> <p><input type="checkbox"/> b. Tested positive for antibodies to AIDS (Human T Cell Lymphotropic, Type III; HTLV-III) virus?</p> <p><b>3. Have you ever:</b></p> <p><input type="checkbox"/> a. Used or currently use barbiturates, amphetamines, hallucinogenic drugs (including Marijuana), narcotics, or any prescription drug except in accordance with a physician's instruction?</p> <p><input type="checkbox"/> b. Received counseling advice or treatment regarding the use of alcohol or drugs?</p> <p><b>4. Are you currently receiving any medical treatment?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>5. Other than in any items already listed, have you, within the past 5 years, been a patient in a clinic, sanitarium, or hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>6. Have you ever used tobacco products?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If you quit, when did you quit?</p> <p><b>7. Have used any tobacco products in the past 12 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>8. Do you currently use a nicotine patch or other nicotine product to help stop smoking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p style="text-align: center;"><b>Details of Yes Answers</b></p> <p><b>Include give dates, diagnosis, details and treatment. Be sure to include names and addresses of all attending physicians and medical facilities</b></p> |
|---|--|

**Personal Health History Continued**

**HEART**

**Have you had any of the following:**

|   |                    |            |
|---|--------------------|------------|
| <input type="checkbox"/> High Blood Pressure?   | Last BP reading?   |            |
| <input type="checkbox"/> High Cholesterol:      | Total Chol. Level: | Ratio:     |
| <input type="checkbox"/> History of Chest Pain? | Evaluated?         | Diagnosis? |
| <input type="checkbox"/> Heart Attack?          | # of attacks       | Dates:     |

Any resulting impairments:

|  |  |   |                      |
|--|--|---|----------------------|
| <input type="checkbox"/> By-Pass Surgery?                    | # of vessels:  | name of vessels:                        | Date:                |
| <input type="checkbox"/> Coronary Angioplasty?               | # of vessels:  | name of vessels:                        | Date:                |
| <input type="checkbox"/> Stent?                              | Which vessels:   |   |                      |
| <input type="checkbox"/> Heart Failure?                      | # of times:  | Congestive?                             |                      |
| <input type="checkbox"/> Valve Surgery?                      | Name of Valve:   | Date:                                   |                      |
| <input type="checkbox"/> Pacemaker?                          | Type:  | Date:                                   |                      |
| <input type="checkbox"/> Atrial Fibrillation?                | <input type="checkbox"/> Chronic   | <input type="checkbox"/> Single Episode |                      |
| <input type="checkbox"/> Premature Ventricular Beats (PVC's) | <input type="checkbox"/> Premature Supraventricular Atrial Beats (PAC's) |   |                      |
| Date of last electrocardiogram:                              | <input type="checkbox"/> Abnormal  | <input type="checkbox"/> Normal         | Attending Physician? |

**Were any of these tests completed:**

|  |       |                                   |                                 |                     |
|--|-------|-----------------------------------|---------------------------------|---------------------|
| <input type="checkbox"/> Stress Electrocardiogram? | Date: | <input type="checkbox"/> Abnormal | <input type="checkbox"/> Normal | Attending Physician |
| <input type="checkbox"/> Echocardiogram?           | Date: | Was it done while exercising?     |                                 |                     |
| <input type="checkbox"/> Thallium Stress EKG?      | Date: | Attending Physician?              |                                 |                     |
| <input type="checkbox"/> Coronary Angiogram?       | Date: | # of diseased vessels             | Attending Physician?            |                     |

**CANCER**

|  |   |            |
|--|---|------------|
| Location of Cancer:                        | Diagnosis Date:                                     |            |
| Exact Name of Cancer:                      |   |            |
| Who would have the Pathology report?       | Number of adjacent Lymph Nodes with abnormal cells: |            |
| Any Radiation or Chemotherapy?             | Date of Last Treatment:                             |            |
| Has there been any reoccurrence of cancer? |   |            |
| IF skin cancer, was it melanoma            | Clarks or Breslows Thickness rating:                |            |
| IF prostate cancer                         | Gleason Score:                                      | Staging:   |
| PSA at diagnosis:                          | Current PSA:  | Treatment: |

**DIABETES**

|  |             |                     |
|--|-------------|---------------------|
| Date of Diagnosis:                                 | Treatment:  | Name of medication: |
| Weight 1 yr ago:                                   | Weight now: | Height:             |
| How often are sugar levels monitored?              |             |                     |
| Date of last test:                                 | Results:    |                     |
| Last Hemoglobin A1C reading:                       | Date:       |                     |
| Last MicroAlbumin leve:                            | Date:       |                     |
| Last Glucose level:                                | Date:       |                     |
| Any complications? (e.g. eyes, heart, kidney, etc) |             |                     |
| Details:   |             |                     |

**Family History**

|          | Age if living | Age at death | History of Cardiovascular Disease | Age of onset | History of Cancer | Age of onset |
|----------|---------------|--------------|-----------------------------------|--------------|-------------------|--------------|
| Father   |               |              |                                   |              |                   |              |
| Mother   |               |              |                                   |              |                   |              |
| Siblings |               |              |                                   |              |                   |              |

# AUTHORIZATION TO RELEASE INFORMATION

American Financial Network LLC or any of the other entities listed below, or their subsidiaries or reinsurers or authorized representatives, any and all such information. I UNDERSTAND that under Federal Regulations I may revoke this authorization as it applies to drug and alcohol abuse treatment at any time; but said revocation will not affect any information that may have been released prior thereto.

I UNDERSTAND that the information obtained by use of this authorization will be used by American Financial Network LLC and the entities listed below, and their subsidiaries and reinsurers, to determine insurability. American Financial Network LLC and the entities listed below, and their subsidiaries and reinsurers, may also release information in their file to other companies to which I may apply for life or health insurance.

I UNDERSTAND that I may request a copy of this form.

I AGREE that a photocopy of this form will be as valid as the original.

This AUTHORIZATION will be valid for 2 years from the date shown below.

|   |  |   |
|---|--|---|
| AIG<br>Allianz Insurance Group<br>American General Life Insurance Company<br>American Life and Annuity Ins. Co.<br>American National Insurance Company<br>AXA Financial<br>Aviva Life and Annuity Company<br>Bankers Life Insurance Co. of NY<br>Banner Life Insurance Company<br>CFC of Delaware LLC and its successors and assigns<br>DH Services<br>Empire General Life Assurance Corp<br>Equitrust Life<br>Fidelity and Guaranty Life Ins. Co.<br>Fidelity and Guaranty life ins. Co. of NY<br>Fort Dearborn life | Genworth Life Insurance Company<br>Genworth Life Insurance Company of NY<br>The Hartford Financial Services Group, Inc<br>John Hancock Life insurance company<br>Lafayette Life Insurance Company<br>Lincoln Financial Group<br>Lincoln Benefit Life<br>Metropolitan life insurance company<br>Mony Life Insurance Company of America<br>Mutual of Omaha<br>Minnesota Life<br>National Western Life<br>North American Life<br>Old Mutual Life<br>Phoenix Life Insurance Company<br>Principal Life Insurance Company<br>Principal National life Insurance Company | Protective Life and Accident Insurance<br>Provident life and Accident Insurance Co.<br>Prudential Insurance Co.<br>Pruco Life Insurance Co. of America<br>Reliastar Life Insurance Co.<br>Reliastar Life Insurance Co. of NY<br>Security Life of Denver Insurance Co.<br>Sun Life Financial<br>Transamerica Insurance & Investment Group<br>Travelers Life & Annuity Co.<br>United States Life Insurance Co.<br>Unum Life Insurance Company<br>Western Reserve Life<br>West Coast Life Insurance Co.<br>Welcome Funds |
|---|--|---|

## NOTICE TO PROPOSED INSURED

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is attained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. The inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. If a report is made, you may request the name, address and telephone number of the consumer reporting agency from whom you may request a copy of the report.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage or a claim of benefits is submitted to such company, the bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of the request from you, the bureau will arrange disclosure of any information it may have in your file. NOTE: (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, Tel. (617)426-3660.

The companies listed in this notice or their reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

|                             |                          |              |
|-----------------------------|--------------------------|--------------|
| <b>CLIENT NAME PRINTED:</b> | <b>Social Security#:</b> | <b>DOB:</b>  |
| <b>CLIENT SIGNATURE:</b>    |                          | <b>DATE:</b> |
| <b>CLIENT NAME PRINTED:</b> | <b>Social Security#:</b> | <b>DOB:</b>  |
| <b>CLIENT SIGNATURE:</b>    |                          | <b>DATE:</b> |