INSURANCE RESOURCE GROUP
9744 Wilshire Blvd. Suite 306
Beverly Hills, CA 90212
888) 224-4777, (310) 550-3300
Fax (310) 550-3390
E-mail sales@irginsurance.com

Client's Name Date of Birth: Sex:

First: Middle: Last:

Street:

City: State: Zip: Weight: Height:

Home Phone: Office Phone: Mobile Phone:

☐ Amount Applying for? $

☐ $500,000 ☐ $6,000,000
☐ $1,000,000 ☐ $7,000,000
☐ $2,000,000 ☐ $8,000,000
☐ $3,000,000 ☐ $9,000,000
☐ $4,000,000 ☐ $10,000,000
☐ $5,000,000 ☐ Other (Specify)

Amount of Current Insurance:

Estimated Net Worth:

Social Security:

Have you ever used any form of tobacco? YES: NO:

If yes, form and frequency: Date of Last use:

Physicians:

1 Name: Phone No: Date last seen:
Street: Reason for Visit:
City: State: Zip:

2 Name: Phone No: Date last seen:
Street: Reason for Visit:
City: State: Zip:

3 Name: Phone No: Date last seen:
Street: Reason for Visit:
City: State: Zip:

4 Name: Phone No: Date last seen:
Street: Reason for Visit:
City: State: Zip:

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Advance Settlements
Allianz
~ American General
~ Aviva
~ AVS Underwriting,LLC
~ AXA
~ Banner
~ Columbus Life
~ Chesapeake
~ Conseco
~ EMS, XE-R, LLC
Fasano Associates Inc
~ F&G
~ First Colony
~ Fidelity Security
~ GE Life
~ General American
~ Guardian
~ GTL
~ Hartford Life
~ Indianapolis
~ ING
~ John Hancock
~ Lincoln Benefit
Lincoln National
~ Manulife
Maple Life Finance
~ Midland National
~ MTL
~ Mass Mutual
~ METLIFE
~ Nationwide
~ New York Life
~ North American
~ Pacific Life
~ Phoenix
~ Principal
~ Prudential
~ Protective
~ Reliastar
~ Reliastar NY
~ Security Connecticut
~ Sun Life
~ Travelers
~ Transamerica
~ United of Omaha
~ West Coast
~ William Penn
~ 21st Service

Any of the companies indicated above will be referred to as "the Company"

Authorization

For Underwriting and claim settlement purposes regarding me or any child(ren) under the age of 15 named below, I authorize:

- Any medical practitioner; any medical facility; any other medical entity; any insurer; any consumer reporting agency; and MIB Group, Inc. (MIB) to give the Company information about me or such child(ren) including:
  - Personal information and data;
  - Medical information, records and data (such as: drugs prescribed; medical test results; and information about sexually transmitted diseases);
  - Information related to alcohol and drug abuse and treatment;
  - Information, records, and data relating to Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, including Human Immuno-deficiency Virus (HIV) test results; and
  - Information, records and data relating to mental illness.
- The Company to redisclose information received pursuant to this Authorization as authorized by me in writing or as otherwise permitted by applicable law.
- The Company to request and obtain: consumer; investigative consumer; or motor vehicle reports.
- Any employer, business associate, financial institution, or government agency to give any of the Companies listed above any information or data that it may have about: occupations; avocations; driving record; finances; character; reputation; and aviation activities.

I understand that:

- Information, records and data received that the Company receives pursuant to this Authorization will be used and maintained by any of the Company described in its **Consumer Privacy Notice,** a copy of which was given to me.
- All or part of the information, records and data that the Company receives pursuant to this Authorization may be disclosed to MIB. Such information may also be disclosed to and used by: any reinsurer; any Company employee; or any affiliate or independent contractor who performs a business service for any of the above mentioned Companies on the insurance applied for or an existing insurance with the Company. Information may also be disclosed as otherwise required or permitted by applicable laws.
- Information related to alcohol and drug abuse that has been disclosed to the Company may be protected by Federal Regulations 42 CFR Part 2. This information may be redisclosed as provided in this Authorization.
- Medical information, records and data disclosed may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, 45 CFR Parts 160-164. These rules set forth standards for the use, maintenance and disclosure of such information by health care providers and health plans.
- Information obtained pursuant to this Authorization about me or such child(ren) may be used, to the extent permitted by law, to determine the insurability of other family members.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- If Underwriting determines that an investigative consumer report is needed, I will be contacted by the consumer reporting agency and interviewed in connection with its preparation.
- This Authorization will end 24 months from the date on this form or sooner if prescribed by law. I may revoke it at any time by writing to the Company advising it that I have revoked this Authorization. Any action taken before the Company has received my revocation will be valid.
- I have a right to receive a copy of this form.

A photocopy of this form is as valid as the original form

SIGNATURES: (Parent or Guardian, if a proposed insured is under age 15, sign on line for proposed insured)
Proposed Insured #1 ___________________________ Date ______________________
Print Name of Proposed Insured #1 ____
Witness : _____________________________________ Date ______________________

9744 Wilshire Blvd. Suite 306 Beverly Hills CA 0212
9Phone : 888-224-4777 Fax : 310-550-339

MEDICAL HISTORY	Have you ever had any indication of, or been treated for any of the following: (Please place an "X" by condition and provide details on the lines provided.)

	CONDITION	DETAILS
	Chest Pain	
	Palpitations	
	High Blood Pressure	
	Heart Disease	
	Heart Murmur	
	Heart Failure	
	Atrial Fib	
	Pacemaker	
	Stint	
	Bypass	
	Angioplasty	
	Other Disorders of Heart	
	Tumor	
	Cancer	
	Leukemia	
	Blood Disorders	
	Cysts	
	Melanoma	
	Lymphoma	
	Lymph Nodes Disorder	
	Diabetes	
	Elevated Blood Sugar	
	Thyroid	
	Other Endocrine or Glandular	
	Asthma	
	Emphysema	
	Allergies	
	Sleep Apnea	
	Tuberculosis	
	Sarcoidosis	
	Persistent Hoarseness	
	Shortness of Breath	
	Other Respiratory Disorder	
	TIA Seizures	
	Fainting	
	Dizziness	
	Epilepsy	
	Stroke	
	Paralysis	
	Other Neurologic Disorder	
	Nervous/Mental Disorder	
	Anxiety	
	Depression	
	Stress	
	Other Emotional Condition	

MEDICAL HISTORY (Continued)

	Ulcers	
	Colitis	
	Jaundice	
	Hepatitis	
	Cirrhosis	
	Intestinal Bleeding	
	Stomach Disorder	
	Esophagus	
	Liver	
	Intestines	
	Gallbladder	
	Pancreas	
	Any Complication of:	
	Testicles	
	Prostate	
	Breasts	
	Ovaries	
	Uterus	
	Cervix	
	Kidney	
	Urinary	
	Bladder	
	Any other Condition	

Additional Details:

MEDICATIONS PRESCRIBED	Please list all medications you have been prescribed below (including name, dosage and frequency):