National Brokerage
6225 Meeker Place, Suite 100
Boise, ID 83713
(800) 377-6344

Trial Application and HIPAA Authorization

Section A - Proposed Insured

1. First, Middle, Last Name:	2. ☐ Male ☐ Female	3. Date of Birth:
4. SSN:	5. Drivers License #:	6. State:
7. US Citizen: ☐ Yes ☐ No If No, Perm. Resident: ☐ Yes ☐ No If No, Visa Type: Country of Citizenship:		
8. Address:		9. City:
10. State:	11. Zip:	12. Occupation:
13. Income:		14. Total Assets:
15. Total Liabilities:		16. Net Worth:
17. Phone Numbers: Home:	Work:	Cell:
18. Fax:		19. Email:

Section B - Insurance Details

Proposed Death Benefit $	Proposed Product:

Existing Coverage

Insurance Company	Policy Number	Type	Year Issued	Face Amount	To be Replaced?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Is there a trial or formal application pending? ☐ Yes ☐ No (If yes, what company?)

Have you ever been declined or rated? ☐ Yes ☐ No (If yes, provide details in "Remarks")

Case Recently Shopped? ☐ Yes ☐ No (If yes, give details on Date, Carrier, Health rating, Will it be placed?)

Section C - Physician Information

Please list all physician's seen in the past 5 years. Please list any additional physicians in "Remarks" section.

Name - Address - Phone	Type of Physician	Date Last Consulted	Reason/Results

Section D – Medical Questionnaire

Have you ever had symptoms of, been diagnosed, or been treated by a physician, clinic, or hospital for any of the following?

	Yes	NO
1. Chest pain, heart murmur, high blood pressure, stroke, irregular heart beat, or other disease or disorder to the heart or arteries?		
2. Have you ever had any type of coronary or vascular surgery?		
3. Diabetes or disease of any gland?		
4. Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?		
5. Arthritis, gout, or any bone, joint, muscle, or skin disorder?		
6. Do you have any type of respiratory disorder requiring ongoing use of oxygen or inhaler and/or breathing difficulty that limits your ability to walk/climb ONE flight of stairs?		
7. Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, or any disorder of the liver or intestines?		
8. Prostate or testicular disease/high PSA, disease of the uterus, ovaries, or breast?		
9. Anemia, leukemia, clotting disorder, platelet disorders, infections or sources of blood loss?		
10. Do you have a history of ANY cancer (including skin cancer such as melanoma)?		
11. An operation or admission to a health care facility for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance within the last 5 years?		
12. Disorder of the urinary tract or kidneys, sugar, albumin, or blood in urine?		
13. Have you been diagnosed with Alzheimer's Disease, dementia or memory loss or do you take any medication for memory enhancement, such as Aricept or Namenda?		
14. Do you require assistance with any activities of daily living, such as walking, bathing, grooming, and/or getting dressed?		

Details for "Yes" answers to Health Questions

Q#	Date Diagnosed(s)	Condition - Details	Physician Name

Section E – Medications

List all Current Medications, Dosages and Prescribing Physician:

Section F – General Risk

Tobacco Use: ☐ Yes ☐ No	Type:	Date Last Used:

Height: Weight:
Has weight changed more than 10 lbs in the past year? ☐ Yes ☐ No (If yes, provide details in "Remarks")

Have you been advised to seek treatment or been treated for alcohol or substance abuse? ☐ Yes ☐ No
(If yes, provide details in "Remarks").

In the past five years, have you been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? ☐ Yes ☐ No

Have you traveled or resided in a foreign country or plan to in the future? ☐ Yes ☐ No
(If yes, provide details in "Remarks").

Section G - Family History

Has any family member (parents / siblings) – been diagnosed with any of the following conditions:

Cancer, diabetes, Heart or Cardiovascular Issues, Huntington's Disease or Kidney Disease - ☐ Yes ☐ No

	Age if living	Present Health	Age deceased	Cause of Death
Mother				
Father				
Sister(s)				
Brother(s)				

Family History Details:

Section H - Agent Information

Name:	Phone Number:	Fax:
Email address:	Date:	

Additional Remarks / Notes: (Please Identify the Question you are answering.)

Financial And Medical Records Authorization

(This authorization complies with the HIPAA Privacy Rule)

Give completed and signed copy to proposed insured

PRIMARY INSURED		
Name (First, M.I., Last)	Date of Birth	Social Security No

ADDITIONAL INSURED		
Name (First, M.I., Last)	Date of Birth	Social Security No

AUTHORIZATION

I authorize National Brokerage and the agent/broker named below, Insurance support organizations (such as MIB, Inc), the companies listed at the bottom and their reinsurers, agents, employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other Insurance coverage, or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to the individuals/entities named above. 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 to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determinations 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company(s).

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to National Brokerage 6225 North Meeker Place Suite 100 Boise, ID 83713 Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers have relied on this authorization or to the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule). I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I do not sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

Revised 3/22/11 NB1200

Companies to Which This Authorization Applies:		
Aegon	Lafayette Life	Protective Life
Accordia	Liberty Life	Prudential / Pruco
Advantage Insurance Network	Life of the Southwest	Reliastar
Allianz Life	Lincoln Benefit	SBLI
American General	Lincoln National	S.B.S. Marketing
American National	Metropolitan	Sagicor
Assurity Life	Minnesota Life	Securian
Athene	Mountain Financial Group	Security Life of Denver
AXA/Equitable	Mutual of Omaha	Select Brokerage Services Inc
Banner Life	Mutual Trust (MTL)	Symetra
Fidelity Life Association	National Brokerage	Transamerica
Genworth	National Life Ins. Co.	Transamerica – Family Markets
Guaranty Income Life / GILICO	Nationwide	United Home
Guardian	North American	United of Omaha
Hartford	Penn Mutual	United States Life
Hooper Holmes	Phoenix Life	Voya
ING	Portamedic	William Penn
John Hancock	Principal Life	Zurich

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient:

_____

_____

_____ _____ _____

Signature of Agent/Broker Name of Agent/Broker Date

X _____ _____

Signature of Proposed Insured/Patient or Personal Representative Date

_____ _____

Signature of Additional Proposed Insured/Patient or Personal Representative Date