Producers Financial Group Select
9 Briarwood Place, Fargo, ND 58104
Phone 800-438-7243 Ext. 216 Fax 701-237-6142
Email: kengler@pfg1.net

Informal Inquiry

Not an application for insurance

Personal History

Name ________________________________ ❑ Male ❑ Female Social Security Number __________________
Address _______________________________________ City ____________________ State ______ Zip ________
Date of Birth _________________ Age ____ Height ______ Weight _____ Monthly Earned Income _____________
Occupation ____

Requested Plan of Insurance – must be completed

Minimum Consideration: Minimum premium of $1000.00 Annual

❑ Universal Life ❑ Whole Life ❑ Term, Level Period _____ ❑ Survivorship* ❑ Variable
Date of last nicotine use ___________ Specify tobacco and amount ___________ Using nicotine gum or patch? ______
Face amount desired __________________ Premium amount desired __________________ ❑ Annually ❑ Monthly
What will be the purpose of the insurance? ____

*If both have insurability questions, complete this form on each.

What adverse action or table rating was offered by another company?

Did your primary company work this case? ❑ Yes ❑ No

Company	Date	Amount	Action	Quoted Premium

Is this case being considered by another Special Risk agency? ❑ Yes ❑ No

Other insurance on Proposed Insured

Total amount in force ___________ Date of last app. _______ Is this insurance to replace other insurance? ❑ Yes ❑ No
Name of Company _________________________________ If so, premium being replaced ____________________

Agent Information

Name ____________________________ Phone No. ____________________ Email address ________________
Address __________________________ City ________________ State _____ Zip ______ Fax No. ______________

Inquiry cannot be considered unless authorization is signed by Proposed Insured

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I (We) acknowledge that I (we) have received written notice that, as part of your procedure for processing my (our) insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with my (our) neighbors, friends, or others with whom I (we) have an acquaintance. This inquiry includes information as to my (our) character, general reputation, personal characteristics, and mode of living. I (We) know that I (we) have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation.

Information regarding your insurability will be treated as confi dential. The Companies named below may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies, which operates an information exchange in behalf of its members. If you apply to another Bureau member company, the Bureau, upon request will supply such company with the information in its file.

Upon receipts of request from you, the Bureau will arrange disclosure of any information it may have in your file. (Medical Information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and send 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, telephone number (617) 426-3660.

The Companies named below may also release file information to their life insurance companies where you may apply for life or health insurance, or to whom a claim may be submitted.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give the companies named below any such information.

This authorization will be valid for two years after the date of signing. A photographic copy of the authorization shall be as valid as the original. By my (our) signature, I (we) indication that we have retained a copy of this information.

Signed at _____________________________________ this _________________ day of ____________________ 20___
Signature of Proposed Insured ____

Allianz
American General
Banner Life
Canada Life
Clarica
Conseco Life
Empire General
Fidelity Security Life
First Colony Life
First Penn Pacific
GE Capital Assurance
Great Southern Life
Guarantee Trust Life
IL Annuity & Assurance
Jefferson Pilot
Jetstream Copy Service
Lincoln Benefit Life
Lincoln National Life
Manulife
New York Life
North American
Old Republic
PFL
Producers Financial Group
Protective Life
Prudential
Southland Life
State Life
Sun Life
United of Omaha
US Financial
West Coast Life
Western Reserve Life

Medical History – this section must be fully complete

1. Who is your personal physician? Doctor's name, address and phone number When and why did you last consult him/her?	Date	Illness and Treatment
2. What other physicians have you consulted during the past five years, and why? (Do not include insurance examinations.)		
3. In what clinics, hospitals, or sanitariums have you ever been treated, and why?		
4. Please list all current medications.		

Please be specific with above information and include phone numbers. It will expedite processing. It is also helpful to know who has results of any special tests.

5. Do you regularly exercise 3 or more times per week? ❑ Yes ❑ No If yes, type ________________________________

6. Family Health History

	Age (if deceased)	Age (if living)	History of heart disease or circulatory disorder	History of cancer, all types
Mother	_____________	____________	❑ Yes ❑ No	❑ Yes ❑ No
Father	_____________	____________	❑ Yes ❑ No	❑ Yes ❑ No
Sister(s)	_____________	____________	❑ Yes ❑ No	❑ Yes ❑ No
Brother(s)	_____________	____________	❑ Yes ❑ No	❑ Yes ❑ No

Drug and Alcohol Usage Questionnaire – if applicable

1. Do you presently use alcoholic beverages? ❑ Yes ❑ No
   If "No," approximate date of last drink: ____-____-____

Quantity:	Beer	Wine	Liquor
Daily	________	________	________
Weekly	________	________	________

2. Did you ever drink substantially more than at present?
   ❑ Yes ❑ No If "Yes," when?
   From ____-____-____ to: ____-____-____

Quantity:	Beer	Wine	Liquor
Daily	________	________	________
Weekly	________	________	________

3. Are you active and attending meetings in AA or other recovery groups? ❑ Yes ❑ No How long?
   ____
   ____
   ____
   ____

4. Because of your alcohol use, have you ever consulted a doctor or received treatment? ❑ Yes ❑ No
5. Have you ever been arrested for driving under the influence of alcohol? ❑ Yes ❑ No
   If "Yes," give details and drivers license number
   ____
   ____
6. Have you ever sought medical treatment because of drug usage or has drug usage ever been a problem?
   ❑ Yes ❑ No
7. Date of last drug use __________________________
   Type of drugs used __________________________

This form is used exclusively to gather specific information on a proposed Insured's medical history and other factors that may contribute to a sub-standard underwriting classification. This is not a formal application for insurance and in no way guarantees a specific underwriting class or binds insurance coverage for the proposed insured.

Chest Pain – Coronary

1. Date of first chest pain? ____-____-____
2. Date of last chest pain? ____-____-____
3. Have you had more than one episode? ❑ Yes ❑ No
4. Were you hospitalized? ❑ Yes ❑ No Where? ____
5. Did you have a heart attack? ❑ Yes ❑ No Treatment? ____
6. Additional information for By-Pass/Angioplasty/Stents
   Dates of surgery: ____-____-____
   Number of diseased vessels: ______________________
   Last stress EKG: ____-____-____
   By whom? ______________________
   Results? ______________________
   Any pain since surgery? ______________________

Cancer

1. Location of cancer ______________________
   Surgery Date: ____-____-____
2. Exact name of cancer (Sarcoma, Carcinoma, Epithelioma, etc.): ______________________
   Stage and Grade: ______________________
3. Who would have the pathology report? ______________________
4. Had the cancer spread outside primary location? ____
5. Any radiation or chemotherapy? ❑ Yes ❑ No
   Date of last treatment: ____-____-____
6. Has there been any reoccurrence of cancer? ❑Yes ❑No
7. If skin cancer, was it melanoma? ❑ Yes ❑ No
   Clark's Level Rating: ______________________

Diabetes

Date of diagnosis: ____-____-____

1. Treatment
   ❑ Diet Only ❑ Oral Medication ❑ Insulin
   Name: _________ Type: __________
   Dosage: ________ Number of Units: _
2. Do you regularly test your blood glucose? ❑ Yes ❑ No
   Results: _________________ Frequency: __________
3. If glycohemoglobin (AIC) test done, give latest result:
   _______________ mg % Date: ____-____-____
4. Have you had protein or microalbumin in the urine recently? ❑ Yes ❑ No
5. Have you ever had:
   a. Any eye trouble? ❑ Y ❑ N
   b. Heart trouble? ❑ Y ❑ N
   c. High blood pressure? ❑ Y ❑ N
   d. Kidney trouble? ❑ Y ❑ N
   e. Neuritis/neuralgia? ❑ Y ❑ N
   f. Insulin reactions? ❑ Y ❑ N
6. Weight one year ago ______ Present weight? _______

Instructions to agent: The notification appearing below must be given to the proposed insured before or at the time of signature.

NOTICE TO PROPOSED INSURED

In connection with your preliminary inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report 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. Upon written request to the life insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

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 for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of 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 apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others, such as medical professionals, who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

The above is a general description of the listed insurance companies and your agent's information practices. If you would like to receive a more detailed explanation of those practices, please send your written request to Producers Financial Group.

Allianz	Clarica	First Penn Pacific	Jefferson Pilot	Manulife	PFL	Prudential	United of Omaha
American General	Conseco Life	GE Capital Assurance	Jetstream Copy Service	New York Life	Producers Financial Group	Southland Life	US Financial
Banner Life	E,mpire General	Great Southern Life	Lincoln Benefit Life	North American		State Life	West Coast Life
Canada Life	Fidelity Security Life	Guarantee Trust Life	Lincoln National Life	Old Republic	Protective Life	Sun Life	Western Reserve Life
	First Colony Life	IL Annuity & Assurance					