Informal Medical Questionnaire

Personal History—Proposed Insured

Name _____ ☐ Male ☐ Female Social Security Number _____

US Citizen? ☐ Yes ☐ No Date of Birth _____ Birth State _____ Phone _____

Age _____ Height _____ Weight _____ Driver's License Number _____ Driver's License State _____

Address _____ City _____ State _____ Zip _____

Lifestyle

Did you lose/gain more than 10 pounds in the past year? ☐ Yes ☐ No If yes, explain reason for weight change: _____

_____

Have you ever used or do you currently use any form of tobacco or nicotine delivery system? ☐ Yes ☐ No

☐ Cigarettes ☐ Chewing tobacco ☐ Cigars ☐ Pipe ☐ E-Cigarettes ☐ Vape ☐ Zyn Other: _____

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly Date Last Used _____

Do you currently use marijuana products? ☐ Yes ☐ No

☐ Medicinal ☐ Recreational Options: ☐ Smoking ☐ Vaping ☐ Edibles ☐ Topical ☐ Other

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly Date Last Used _____

Any history of treatment of drug/alcohol use? ☐ Yes ☐ No If yes, explain or complete alcohol/drug questionnaire: _____

_____

Any history of moving violations? ☐ Yes ☐ No If yes, explain or complete driving questionnaire: _____

_____

Are you a pilot and/or do you participate in any activities such as scuba diving, rock climbing, motor cross, etc.? ☐ Yes ☐ No

If yes, provide details: _____

Do you intend to reside or travel outside of the United States within the next two years? ☐ Yes ☐ No

If yes, please provide city, country, dates/duration and purpose of all travel: _____

_____

Requested Coverage

☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship ☐ Variable Is LTC desired? ☐ Yes ☐ No

Face amount desired $ _____ Premium amount desired $ _____

What will be the purpose of the insurance? _____

Have you ever been declined or rated when applying for life insurance? ☐ Yes ☐ No

If yes, when and why? _____

THE PINNACLE GROUP

Informal Medical Questionnaire

Existing Insurance *Do you currently have active insurance coverage? Will this coverage be replaced?*

Company	Type	Amount	Replacing
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Medical History *Please answer the following questions and provide detail to any "yes" answers.*

Who is your personal physician? (Doctor's name, address, and phone number)

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

What other medical practitioners or health care providers have you consulted in the past 5 years, not including insurance examinations?

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

Name _____ Address _____

City _____ State _____ Zip _____ Phone _____

Date seen: _____ Reason/Diagnosis: _____

In what clinics or hospitals have you been treated?

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

_____ Date seen: _____ Reason/Diagnosis: _____

Please list all current medications, purposes, and doses (both prescribed and non-prescribed)

Do you have any upcoming procedure or office visit planned with any physician? ☐ Yes ☐ No

If yes, please give details: _____

Informal Medical Questionnaire

Medical History Continued *Please answer the following questions and provide detail to any "yes" answers.*

Any cancer, cardiovascular, or diabetes history/deaths prior to age 60 among your parents or siblings? ☐ Yes ☐ No

	If living, please provide age:	If deceased, please provide age at death and cause of death:		Cancer of any type
Mother	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Father	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Sibling	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No
Sibling	Age _____	Age at death _____	Cause of death _____	☐ Yes ☐ No

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:

Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heartbeat, or any other disease or disorder of the heart or arteries? ☐ Yes ☐ No

Diabetes or disease of any glands? ☐ Yes ☐ No

Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system? ☐ Yes ☐ No

Arthritis, gout, or any bone, joint, muscle, or skin disorder? ☐ Yes ☐ No

Asthma, bronchitis, pneumonia, emphysema, or any lung disorder? ☐ Yes ☐ No

Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder pancreas, stomach, or intestines? ☐ Yes ☐ No

Prostate of testicular disease, disease of the uterus, ovaries, or breast? ☐ Yes ☐ No

Anemia, leukemia, clotting disorders, or platelet disorders? ☐ Yes ☐ No

Disorder of the urinary tract or kidneys - sugar, albumin, or blood in the urine? ☐ Yes ☐ No

Cancer or tumors? ☐ Yes ☐ No

An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance)? ☐ Yes ☐ No

Any other health impairment or medically treated condition not previously mentioned? ☐ Yes ☐ No

Within the last 10 years, have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)? ☐ Yes ☐ No

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS in the space below. Attach additional pages if necessary. Please be specific with this information for it will expedite the process.

Agent Information

Name _____ Firm _____

Social Security Number _____ Phone _____

Authorization for Release of Health-Related Information

Client Information:

Name of Person Covered by this Authorization

Date of Birth

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 payment, 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 personal health information concerning me to any of the companies on the "List of Companies" page located within this document, its agents, employees, representatives, and affiliated companies (collectively referred to as "The Companies"). 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. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes (meaning the following information is included in this authorization) medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 Companies.

This authorization shall remain in force for 24 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 The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Authorization:

Signature of Proposed Insured, Patient, or Personal Representative

Today's Date

Proposed Insured, Patient, or Personal Representative Printed Name

Description of Personal Representative's Authority or Relationship to Patient

Advisor Information:

Name of Advisor

Advisor Email

Updated 4/23/26

Authorization for Release of Personal Psychotherapy Notes

Client Information:

Name of Person Covered by this Authorization

Date of Birth

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 payment, 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 personal health information solely relating to psychotherapy notes to any of the companies on the "List of Companies" page located within this document, its agents, employees, representatives, and affiliated companies (collectively referred to as "The Companies"). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversion during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of your medical record.

By my signature below, I acknowledge that any agreements I have made to restrict my personal health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record as described above without restriction.

This personal health information is to be disclosed under this Authorization so that The Companies may: 1) underwrite my application for coverage, make eligibility, risk rating, policy 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 Companies.

This authorization shall remain in force for 24 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 The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record as described above, The Companies may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

Authorization:

Signature of Proposed Insured, Patient, or Personal Representative

Today's Date

Proposed Insured, Patient, or Personal Representative Printed Name

Description of Personal Representative's Authority or Relationship to Patient

Advisor Information:

Name of Advisor

Advisor Email

Updated 4/23/26

Authorization to Obtain and Disclose Information

Client Information:

Name of Person Covered by this Authorization

Date of Birth

I understand that any Company named on the "List of Companies" page located within this document, its re-insurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. The types of records and information will include facts about my: (1) mental and physical health including any history of STD or HIV or other communicable diseases; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) occupation; (9) other personal traits.

If for a Lifetime Settlement, I understand that settlement providers and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purpose of pursuing and/or completing the sale of life insurance policy(ies) of which I am the owner, or which I am the insured, and I hereby expressly authorize such use and disclosure.

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 payment, 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 personal health information concerning me to any of the companies on the "List of Companies" page located within this document, its agents, employees, representatives, and affiliated companies. 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.

This authorization shall remain in force for 24 months following the date of my signature below. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to The Companies, to the attention Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that The Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Companies may not be able to process my application.

LIST OF COMPANIES FOUND ON NEXT PAGE

Authorization:

Signature of Proposed Insured, Patient, or Personal Representative

Today's Date

Proposed Insured, Patient, or Personal Representative Printed Name

Description of Personal Representative's Authority or Relationship to Patient

Advisor Information:

Name of Advisor

Advisor Email

List of Companies

Accordia Life	New Business, 611 Fifth Avenue, Des Moines, IA 50309-1603
Advantage Insurance Network	2801 Towngate Rd. Suite 350, Westlake Village, CA 91361
American General Life Companies	750 West Virginia Street, Milwaukee, WI, 53204-1539
Allianz	PO Box 1344, Minneapolis, MN 55416-1297
American National	New Business Department, 1 Moody Plaza, Galveston, TX 77550-7947
Ameritas	PO Box 81889, Lincoln, Nebraska 68501
Apeiron Gate	20105 Metcalf Ave, Bucyrus, KS 66013
Ashar Group	1800 Pembrook Dr, Ste 240, Orlando, FL 32810
AXA-Equitable Life	New Business Department, 80 Scott Swamp Road, Farmington, CT 06032-2847
Banner Life	1701 Research BLVD, Rockville, Maryland 20850-3131
Brighthouse	One City Place 185 Asylum Street, Hartford CT 06103-3401
Columbus Life	400 East Fourth St, Cincinnati, OH 45202
EMSI	3050 Regent Blvd., Ste. 100, Irving, TX 75043
Exam One	10101 Renner Blvd., Lenexa, KS 66219
Foresters	PO Box 179, Buffalo, NY 14201
Global Atlantic	215 10th St., Ste 1100, Des Moines, IA 50309
IBU, Inc.	100 Pearl Street, 14th Floor • Hartford, CT 06103
John Hancock Life Insurance	Life New Business, 200 Bloor Street East, Toronto, Ontario, M4W1E5, Canada
Jet Stream APS	1663 Sawtelle Blvd #210, Los Angeles, CA 90025
Lincoln Financial Group	350 Church Street, Hartford, CT 06103-1106
Massachusetts Mutual Life Insurance Co	1295 State St, Springfield, MA 01111
MediFlash	1251 W Acacia Ave, Hemet, CA 92543
MIB, LLC	50 Braintree Hill Park, Braintree, MA 02184
Minnesota Life Insurance	400 Robert Street North, St. Paul, MN 55101
Mutual of Omaha	Mutual of Omaha Plaza, Omaha, NE 68175
National Life Group	1 National Life Drive, Montpelier, VT 05604-1000
Nationwide Life	One Nationwide Plaza, Columbus, OH 43215-2220
New York Life Insurance Company	51 Madison Avenue, Suite 3200, New York, NY 10010
North American	525 West Van Buren, Chicago, IL 60607
OneAmerica Financial	P.O. Box 368, Indianapolis, IN 46206-0368
Pacific Life Insurance Co.	26642 Town Centre Drive, Room 42-3, Foothill Ranch, CA 96210-2808
Pan-American Life Insurance Group	601 Poydras Street, New Orleans, LA 70130
Penn Mutual	600 Dresher Road, Horsham, PA 19044
Petersen International Underwriters	23929 Valencia Boulevard, Second Floor, Valencia, CA 91355
Pinnacle Insurance and Financial Services, LLC	12724 Gran Bay Pkwy, Lakeside 1, Ste 150, Jacksonville, FL 32258
Principal National Life Insurance Company	IDPC – 8th-Floor 801, Grand Ave, Des Moines, IA 50392-2706
Pro Scan Partners	23052-H Alicia Pkwy #636, Mission Viejo, CA 92692
Protective Life Insurance Co.	New Business Department, 2801 Highway 280 South, Birmingham, AL 35223
Prudential Financial	Life New Business, 2102 Welsh Road, Suite DTY, Dresher, PA 19025-5500
Superior Mobile Medics	3838 Camino Del Rio N., Suite 250, San Diego, CA 92108
Symetra Life Insurance Co.	777 108th Avenue NE, Suite 1200, Bellevue WA 98004-5135
Transamerica Life Insurance Co.	Life New Business, 4333 Edgewood Road NE, Cedar Rapids, IA 52499-0001
VOYA	Life New Business, 2000 21st Avenue NW, Minot, ND 58703-0890
Zurich	1400 American Lane, Schaumburg, IL 60196

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