





## APPLICANT'S DIABETIC QUESTIONNAIRE

1. Date diabetes diagnosed \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 2 years ago \_\_\_\_\_
2. Name and address of physician currently supervising you diabetes: \_\_\_\_\_
3. Is urine sugar free: a) Now? \_\_\_\_\_ b) Always? \_\_\_\_\_ c) Date of last test \_\_\_\_\_
4. Fasting blood sugar: Date \_\_\_\_\_ Result \_\_\_\_\_
5. Glycohemoglobin: Date \_\_\_\_\_ Result \_\_\_\_\_
6. What is the present treatment?: Diet only \_\_\_\_\_ Oral Medication \_\_\_\_\_ Insulin \_\_\_\_\_ Units per day \_\_\_\_\_
7. Have you ever had? : Kidney disorder \_\_\_\_\_ Eye disorder \_\_\_\_\_ Hypertension \_\_\_\_\_ Heart disorder \_\_\_\_\_  
( if yes to heart disorder, please complete Heart Disease/Chest Pain Questionnaire )
8. Has an Electrocardiogram been taken? \_\_\_\_\_ Date \_\_\_\_\_ Stress test \_\_\_\_\_ Date \_\_\_\_\_  
  
By whom? \_\_\_\_\_  
  
Was the Electrocardiogram reported normal? \_\_\_\_\_ Was the stress test reported normal? \_\_\_\_\_

## APPLICANT'S HEART DISEASE QUESTIONNAIRE

- 1) Have any of the following ever been experienced? a) Chest Pain \_\_\_\_\_ Palpitation \_\_\_\_\_ Shortness of Breath \_\_\_\_\_  
Other Chest Discomfort \_\_\_\_\_ b) Was it associated with? Exertion / Exercise \_\_\_\_\_ Excitement / Strain \_\_\_\_\_  
Meals? \_\_\_\_\_
- 2) a) Approximate date of first episode \_\_\_\_\_ b) Date of last episode \_\_\_\_\_  
c) How frequently did the episodes occur? \_\_\_\_\_ d) Duration of episodes \_\_\_\_\_  
e) Hospitalized? \_\_\_\_\_ Date admitted \_\_\_\_\_ Date discharged \_\_\_\_\_
- 3) Was bypass surgery done? \_\_\_\_\_ Single \_\_\_\_\_ Double \_\_\_\_\_ Triple or more \_\_\_\_\_
- 4) Was angioplasty done? \_\_\_\_\_ 5) When was last electrocardiogram taken? \_\_\_\_\_ 6) Stress/Treadmill? \_\_\_\_\_
- 7) Have you ever had an angiogram or heart catheterization? \_\_\_\_\_ Date \_\_\_\_\_  
What was the Left Ventricular Function? ( please contact your cardiologist for this test result ) \_\_\_\_\_
- 8) Date of return to work? \_\_\_\_\_ Restrictions? \_\_\_\_\_
- 9) What medication is taken now? \_\_\_\_\_
- 10) What diagnosis was made concerning the heart condition? \_\_\_\_\_
- 11) Give names and addresses of all physicians consulted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPLICANT'S ALCOHOL USAGE QUESTIONNAIRE

- 1) Do you consume alcohol at the present time? \_\_\_\_\_ 2) Are you involved in AA or any other support group? \_\_\_\_\_  
3) Have you ever had alcohol treatment or counseling? \_\_\_\_\_ 4) Date of last drink? \_\_\_\_\_

APPLICANT'S CANCER QUESTIONNAIRE

- 1) Date of diagnosis \_\_\_\_\_ 2) Type of Cancer (give full medical name) \_\_\_\_\_  
3) Stage, level or grade (*please contact your physician if not known*) \_\_\_\_\_  
4) Location of cancer \_\_\_\_\_ 5) Type of treatment given \_\_\_\_\_  
6) Date treatment started \_\_\_\_\_ Date of last treatment \_\_\_\_\_  
7) Date of last follow-up \_\_\_\_\_ 8) Give names and addresses of all physicians consulted: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPLICANT'S FOREIGN TRAVEL QUESTIONNAIRE

- 1) Are you a U.S. citizen by birth? \_\_\_\_\_ a naturalized citizen of the U.S.? \_\_\_\_\_ a citizen of a country other than the U.S.? \_\_\_\_\_  
2) If you are a naturalized citizen, where were you born? \_\_\_\_\_ How long have you lived in the U.S.? \_\_\_\_\_  
3) If you are a non-citizen, of what country are you now a citizen? \_\_\_\_\_ Indicate type of Visa: permanent? \_\_\_\_\_ temporary? (*give expiration date*) \_\_\_\_\_ Indicate purpose of Visa (*work, student, government employee etc*) \_\_\_\_\_  
Have you applied for U.S. citizenship? \_\_\_\_\_ Do you maintain a foreign residence? \_\_\_\_\_ if so, what is the address? \_\_\_\_\_  
Where does your immediate family reside? \_\_\_\_\_ How long have you lived in the U.S.? \_\_\_\_\_  
4) Did you live or travel outside the U.S. in the last 2 years? \_\_\_\_\_ Do you plan to live or travel outside the U.S. in the next 12mos? \_\_\_\_\_

<u>City</u>	<u>Country</u>	<u>Purpose (give full details)</u>	<u>Date</u>	<u>Length of stay</u>
-------------	----------------	------------------------------------	-------------	-----------------------

- 5) Indicate type of foreign environment (Metropolitan, Rural/Agricultural, Primitive/Native etc.) \_\_\_\_\_  
\_\_\_\_\_



## HIPAA Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Life Plans Unlimited / GBS Insurance and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

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 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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 with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Life Plans Unlimited / GBS Insurance. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Life Plans Unlimited and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Life Plans Unlimited may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

\_\_\_\_\_  
**Proposed Insured's Name**

\_\_\_\_\_  
**Proposed Insured's Signature**

\_\_\_\_\_  
**Signed and Dated On**

\_\_\_\_\_  
**At (City, State, Zip Code)**

**Agent / Witness** \_\_\_\_\_

AIG, American General Life Insurance Company, American National Insurance Companies, AXA/Equitable Life Insurance Company, Aviva Life & Annuity, Aviva Life & Annuity of NY, Banner Life Insurance Company, Centrian Life Insurance, Companion Life Insurance Company, Genworth Financial Family of Companies, Hartford Life Insurance & Annuity Company, ING USA Annuity and Life Insurance Company, John Hancock Life Insurance Company, Lincoln Benefit Life, Lincoln Financial Group, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, Penn Mutual Life, Phoenix Life Insurance Company, The Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Savings Bank Life Insurance Company of Massachusetts, Security Life of Denver Insurance Company, Sun Life Financial, Sun Life Insurance & Annuity Co. of NY, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, West Coast Life Insurance Company, William Penn Life Insurance Company of New York