JET-QUOTE EVALUATOR

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PROPOSED INSURED

Name (Please Print):____

Sex : M ___ F ____ Date of Birth:_____________ Place of Birth: ________________

Social Security #: ___________________ Married ____ Single ____ Divorced ____ Widowed ____

Residence Address: ____
Street City State Zip

Occupation *(Type of industry, duties)*: ___________________________________

Net Worth:_________________________ Average Annual Income:_______________________

INSURANCE

Plan : Term ____ *#Years* ____ Universal Life_____ Whole Life_____ Face Amount:_________________

Beneficiary (Name & Relationship): ____

Amount of Insurance in Force: __________________ Is this Insurance intended to replace or change existing insurance or annuities?__________________ If "yes" please provide name of company, plan, amount and issue date:____

Last rated offer for insurance was $_____________ per thousand, on _____/_____/_____. Table ______

By ____
insurance company

MEDICAL HISTORY

1) Height ____ feet ____ inches **Weight** ______ lbs

2) Do you smoke cigarettes? ____ yes ____ no
a. If "yes", for how long? _____ years
number of cigarettes per day? _____
b. If "no", ___ never smoked___ stopped smoking mo. _____
yr. _____
number of cigarettes formerly smoked per day _________

3) Do you use nicotine in any other form? ____ yes ___ no
a. If "yes" ____ pipe ____ cigar ____ chew ____ other

4) Is proposed insured currently under medication or treatment for any disease, condition or disorder?
___ yes ___ no

5) Has the proposed insured ever had?

a. Any physical or mental impairment? Describe fully. ___ yes ___ no
b. Insurance or reinstatement declined, postponed, limited or offered on a special class basis?
___ yes ___ no
c . Any past, present or expected aviation activities or hazardous sports, avocation or hobbies? Give frequency, type, special hazards. ___ yes ___ no

d. Heart problems?(murmur, pain or pressure in chest, shortness of breath, or heart attack) If "yes" provide details in #10 and complete Heart Disease Questionnaire on next page. ___ yes ___ no

e. Treatment for high blood pressure? ___ yes ___ no

f. Diabetes? If "yes" provide details in #10 and complete Diabetes Questionnaire on next page.
___ yes ___ no

g. Cancer or tumor? If "yes" provide details in #10 and complete cancer questionnaire on next page
___ yes ___ no

h. Epilepsy, fainting spells, nervous or mental condition or any disorder of brain or nervous system?
___ yes ___ no

i. Disorder of lungs or respiratory system?
___ yes ___ no

j. Disorder of stomach, intestine, rectum, liver, kidney or gall bladder? ___ yes ___ no

6) Has proposed insured ever had license suspended or revoked? If "yes", include driver's license number.

___ yes ___ no

7) Has proposed insured used narcotics, sedatives or tranquilizers not prescribed by an M.D.?
___ yes ___no

8) Has proposed insured ever had difficulty with legal authorities or employers from use from alcohol or drugs? If "yes" please complete alcohol usage questionnaire on next page. ___ yes ___ no

9) Is there any reason for submitting this trial which is not described above? Explain in #10.
___ yes ___ no

Family History	Age if Living	Age at Death	Cause of Death
Father			
Mother			
Siblings # living___ # dead ___			

10) Please provide details to all "yes" answers (include question number, name & addresses of all treating physicians/hospitals, dates, etc.):

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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 catherization?** ______________ Date ___________________

   What was the Left Ventrical 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? ______

City	Country	Purpose (give full details)	Date	Length of stay

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

____

ADDITIONAL DETAILS /OVERFLOW PAGE

(please specifically refer to correct questionnaire, question numbers 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 ______________________________

AI G, 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 Financial Group, 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