



AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured: _____ Date of Birth _____

Agent Information:

Name: _____ Phone _____ e-mail _____

Carriers:

American General/US Life	Lincoln Financial	Prudential Financial
American National	Lincoln Benefit Life	Principal
AVIVA	Mass Mutual	Pacific Life
AXA Equitable	Met Life	Protective
Banner	Minnesota Life	Sun Life Financial
Coventry	Nationwide	Transamerica
Genworth	National Group Life	United of Omaha/Companion
ING	North American Co.	Union Central
John Hancock	New York Life	Welcome Funds
Kemper Inv/Zurich Am Life Ins	Phoenix	West Coast Life
		William Penn

For the purpose of determining that I, the proposed insured identified above, am eligible for proposed insurance, I authorize any: (1) person licensed to provide health care services; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) health care plan; (6) consumer reporting agency (including, for these purposes, MIB Inc.);(7) financial institution; (8) employer; and (9) family members and associates, to furnish the types of information listed below to one or more of the Companies identified above when this Authorization (or a copy of it) is presented. To facilitate this determination, I further authorize all such persons, except MIB, Inc, to give such information to The Bollinger Group, Inc.

The types of information that may be disclosed include

- My entire medical file for the last ten (10) years, including information regarding my mental and physical health (other than psychotherapy notes); and
- Other information, such as information about my other insurance coverage; hazardous activities; character; general reputation; finances; occupation and other personal traits.

I understand that medical and health related information may be protected by federal and state laws, including federal privacy rules issued by the Department of Health and Human Services, 45 CFR Parts 160-164, and may no longer be subject to those rules once released pursuant to this Authorization.

I understand that The Bollinger Group Inc., and the Companies named above may disclose information obtained under this authorization to third parties only to the extent permitted or required by applicable state and federal laws. Such disclosures include (but are not limited to) disclosures pursuant to an authorization signed by me and disclosures to reinsurers, MIB Inc. and other persons who perform business, professional or insurance tasks related to the proposed insurance.

I understand that I have a right to revoke this Authorization at any time and may do so by writing to The Bollinger Group, Inc. at 11555 Heron Bay Blvd #101, Coral Springs, FL 33076. I further understand, however, that any action taken in reliance on this Authorization prior to receipt of my revocation by The Bollinger Group, Inc. will remain valid.

This Authorization will be valid for 12 months after the date it is signed. **A copy of this authorization will be as valid as the original.** I have a right to receive a copy of this form.

_____ Date _____

Signature of Proposed Insured Named Above or Legally Authorized Representative of Proposed Insured

If signing as Legal Representative, print name below and describe legal authority (e.g., parent, or court appt guardian of a minor child)

Signature of Minor Child
(only if Proposed Insured and is aged 15 or more, or otherwise required)

Legal Representative/Relationship



Date:
PRELIMINARY INQUIRY
Not an application for life insurance

HEALTH HISTORY QUESTIONNAIRE

CLIENT INFORMATION

All questions contained in this questionnaire are strictly confidential.

Proposed Insured Name;	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
Height _____ Weight _____	Tobacco/Nicotine Usage:		
	1. Have you ever smoke cigarettes: Y / N if yes, date of last use.		
	2. Have you used other tobacco or nicotine containing product: Y / N If yes, provide type and last date of use:		

AGENT INFORMATION

Name: _____	Telephone: _____	Fax: _____
e-mail: _____	Address: _____	

MEDICAL HISTORY – PRIMARY CARE PHYSICIAN

Doctor's Name:	Address:
Date Seen and Reason:	

MEDICAL HISTORY – OTHER DOCTORS CONSULTED IN THE PAST 5 YEARS

Date	Reason	Doctor Address
1.		
2.		
3.		
4.		

HOSPITALIZATIONS: (Hospital, Clinic or other Health Facility where you have been treated)

Date	Reason	Hospital/Clinic/Health Facility
1.		
2.		
3.		

