McQueenKalligan
Insurance Services, Inc.

Preliminary Health Questionnaire

Please fax completed forms:
(619) 295-9939
Phone: (800) 294-9936

Client Name: _____ **Date of Birth:** _____

Height: ____ **Ft.** ____ **In.** **Weight:** _____ **Lbs.** **Social Security #:** _____

Amount of Insurance: _____ **Plan (circle one):** **Term** **Universal Life** **Whole Life**

Tobacco User: **Yes** **No** **If yes, circle type(s) of usage:** **Cigarettes** **Cigars** **Pipe** **Chew**
Frequency of use: _____

User of Marijuana? **Yes** **No** **If yes, circle method:** **Smoking** **Edibles**
Frequency of use/week: _____

Has any immediate relative (father, mother, sister, brother) has an occurrence of, or died from, heart disease, diabetes complications, or cancer prior to the age of 60? If yes, please specify.

_____

_____

_____

_____

Ever been treated for elevated blood pressure? **Yes** **No** **List date of diagnosis:** _____
How long has BP been controlled? _____
Most recent BP readings: _____
Medications taken for BP: _____

Ever been treated for elevated cholesterol? **Yes** **No** **List date of diagnosis:** _____
How long has cholesterol been controlled? _____
Most recent cholesterol readings: _____
Medications taken for cholesterol: _____

Angioplasties, bypass, etc.? (dates, reason, number) _____

_____

Any cancer or surgery in the past 20 years? (dates, currently under treatment or resolved) _____

_____

_____

Any history of diabetes? (type, duration, A1C reading) _____

_____

_____

Name all medications currently taken (if not listed above), including dosage and frequency.

_____

_____

_____

Any history of drug or alcohol abuse? _____

_____

More than 2 moving violations in 3 years, DUI, or suspension in past 5 years? _____

_____

Resident Status: (circle one) **U.S. Citizen** **Permanent Resident** **Green Card Holder**
Other Visa (Specify): _____

Do you fly an airplane or participate in any other hazardous activities (scuba diving, sky diving, etc.)?

_____

Any other medical impairment(s)? _____

_____

_____

_____

_____

_____

_____

_____

Physicians/Hospitals visited in the last 5 years:

Physician/Hospital Name _____
Street Address _____
City, State, ZIP _____
Date & Reason for Visit _____

Physician/Hospital Name _____
Street Address _____
City, State, ZIP _____
Date & Reason for Visit _____

Broker Information:
Name: _____
Phone Number: _____
Email: _____

For any questions or for supplemental medical questionnaires, please contact our office at:

McQueen Kalligan Insurance Services, Inc.
404 Camino Del Rio South, Suite #505
San Diego, CA 92108
Phone: (800) 294-9936 / (619) 295-9935
Fax: (619) 295-9939
www.mkisinc.com

McQueenKalligan
Insurance Services, Inc.

Authorization for Release of Information

I hereby authorize **McQueen Kalligan Insurance Services, Inc.** ("my Representative") and its staff, affiliated companies and/or entities, insurance companies and their re-insurers, companies or entities who are Pharmacies and Pharmacy Benefit Managers (PBMs), to possess, obtain and/or re-disclose my existing personal financial and health information for the sole purpose of the procurement of life, health, long term care, or other insurance products. 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 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 reinsurers. Personal health information authorized to be disclosed includes "Pharmacy records" or "Prescription records" in combination with "other organization, institution or person that has any records or knowledge of me." , "medically related facility", "medically related entity" or "pharmacy related service organization" as the entity to disclose PHI. 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 terminate any agreements I have made with my Providers to restrict my medical records and any associated HIPAA protected health information and I instruct my Providers to release and disclose my entire medical record without restriction. I understand that any information that is disclosed pursuant to this authorization may be redisclosed 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 McQueen Kalligan Insurance Services, Inc.'s affiliated insurance companies and their re-insurers. The records may be transmitted via U.S. regular mail, various overnight mail services and through the use of secured electronic devices. 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, insurance companies may not be able to offer insurance coverage, process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

INSTRUCTION TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

American General	AXA Equitable	VOYA	Legal & General/Banner Life	John Hancock
Lincoln Financial Group	Brighthouse Fin/MetLife	Nationwide	Prudential	Exam One
Transamerica	Zurich NA	ANICO	AVS Underwriting LLC	Principal Insurance Co
Accordia/Global Atlantic	Minnesota Life	LSW/National Life	Protective Life	Genworth
Mutual of Omaha	OneAmerica/State Life	Datafied	North American	Principal National Life
AimcoR Underwriting Services		Legal&General/Banner		

Insured's Name: _____ Insured's Signature: _____

Date of Birth: _____

Date: _____ at _____
(City, State, Zip Code)

Agent/Witness Signature: _____

NOTICE TO PROPOSED INSURED

In connection with your formal 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 other whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics and mode of living. 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 which 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 organization of life insurance companies which operates on informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information is may have in its file.

Upon receipt of a request form you, the Bureau will arrange a disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction 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 (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 may 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 that have treated you.

In some situations and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

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

You have the right to revoke this authorization by sending written request to 11021 Winners Circle, #204, Los Alamitos, CA 90720 Attn: Authorization. Alternatively you may revoke the authorization by sending a written request directly to My Providers.

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 these practices, please send your request to:
***McQueen Kalligan Insurance Services, Inc.,* 11021 Winners Circle, #204, Los Alamitos, CA 90720.**