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## INSTRUCTIONS FOR PRELIMINARY INQUIRIES

***PLEASE NOTE THAT PRELIMINARY INQUIRIES SHOULD BE USED ONLY FOR POLICIES WITH FACE AMOUNTS OF \$1,000,000 OR GREATER AND PREMIUMS OF \$10,000 OR GREATER. ALL OTHER INQUIRIES SHOULD BE PHONED TO AARON ADVANTAGE.***

- 1. PRELIMINARY INQUIRY: COMPLETE IN FULL ALL APPLICABLE SECTIONS OF THE FORM. IMPORTANT: IN THE MEDICAL HISTORY SECTION, BE SURE TO INCLUDE THE PHYSICIAN(S) FULL NAME, ADDRESS, AND PHONE NUMBER IN ORDER TO EXPEDITE THE APS ORDERING PROCESS.***
- 2. AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION: SIGN AND PROVIDE YOUR DATE OF BIRTH.***
- 3. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION: SIGN AND DATE BOTH PAGES.***

**PLEASE NOTE THAT YOUR APPLICATION CANNOT BE PROCESSED WITHOUT THE REQUIREMENTS LISTED ABOVE. FORWARD ALL DOCUMENTS TO:**

**AARON ADVANTAGE AGENCY  
7204 GLEN FOREST DRIVE  
SUITE 202  
RICHMOND VA 23226**

**IF YOU SHOULD HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT OUR OFFICE AT (800) 741-0346.**



**ADVANTAGE INSURANCE NETWORK**

*Investments are offered through registered representatives of Jefferson Pilot Securities Corporation  
BRANCH OFFICE: 4232 Brownsville Road • Suite 137 • Pittsburgh PA 15227 • (412) 882-4198*



**Aaron Advantage Agency:**

7204 Glen Forest Drive  
Suite 202

**PRELIMINARY INQUIRY (Confidential) - NOT an application for insurance**

**Richmond, VA 23226**

AGENT						
Agent Name:			E-Mail:			
Address:		City:		State:	Zip:	
Phone #	Fax #	Is this case <input type="checkbox"/> Y If yes, where? being shopped? <input type="checkbox"/> N				
Is a Trial or Formal application pending or <input type="checkbox"/> Y If yes, what Company(s) contemplated with any Insurance Company? <input type="checkbox"/> N						
CLIENT						
PROPOSED INSURED'S FULL NAME		SEX	DOB	HEIGHT	WEIGHT	SOCIAL SECURITY #
PRESENT ADDRESS				PLACE OF BIRTH		
OCCUPATION		TITLE/POSITION		JOB DUTIES		HOW LONG
AVOCATION <input type="checkbox"/> Scuba Diver <input type="checkbox"/> Personal Aircraft Pilot <input type="checkbox"/> Motorcar or Motorcycle Racer <input type="checkbox"/> Sky Diver <input type="checkbox"/> Other, please list:				TOBACCO USE WITHIN LAST FIVE YEARS <input type="checkbox"/> Y, if yes, what type? <input type="checkbox"/> N		
COVERAGE						
AMOUNT OF PROPOSED INSURANCE		TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Survivorship		TYPE OF PLAN <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> VUL		BENEFICIARY
IS THIS A REPLACEMENT POLICY? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please complete the following:						
COMPANY(S)		COVERAGE AMOUNT	ISSUE DATE	RATING	PLAN TYPE	SURRENDER VALUE
HAVE YOU EVER BEEN DECLINED FOR COVERAGE OR BEEN RATED? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please complete the following:						
COMPANY(S)		DATE	RATING	REASON (please be specific)		
IS THIS A PRELIMINARY INQUIRY FOR A LIFETIME SETTLEMENT? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please complete the reverse side too						
MEDICAL HISTORY						
PHYSICIANS AND/OR HOSPITALS CONSULTED		DATE	CONDITIONS CONSULTED & TREATMENTS RECEIVED (if any)			
Name:						
Address:						
Phone/Fax #:						
Name:						
Address:						
Phone/Fax #:						
Name:						
Address:						
Phone/Fax #:						
MEDICATIONS CURRENTLY PRESCRIBED				DOSAGE		
1)	3)	1)	3)			
2)	4)	2)	4)			
HAD A PARENT, BROTHER, OR SISTER WHO HAD CANCER, DIABETES, HEART DISEASE, OR WHO COMMITTED SUICIDE? <input type="checkbox"/> Y <input type="checkbox"/> N						
Relation:		Diagnosis:		Onset:		Death:
Relation:		Diagnosis:		Onset:		Death:
Relation:		Diagnosis:		Onset:		Death:



**AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION**

I understand that the life insurance and/or settlement companies (which practice in the buying and selling of existing life insurance) named below, their reinsurers, any insurance support organizations, and the representatives of these companies may need to collect information on me in regard to my existing and/or proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to evaluate my insurance application to Aaron Advantage Agency, Inc. I authorize my current insurance company to furnish Aaron Advantage Agency, Inc. and/or its authorized representatives with any information and forms in connection with my policy including any conversions or replacements thereof.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit or other personal traits.

The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program.

The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I understand that I may request to receive a copy of this authorization and that I may revoke my consent at any time by sending written notice of my revocation to Aaron Advantage Agency, Inc. I acknowledge receipt of the Notice to proposed Insured and Notice of Information Practices.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_

21st Services, LLC.  
Aaron Advantage Agency, Inc.  
Advantage Insurance Network, Inc.  
Advanced Settlements, LLC  
Allianz  
American General Life (AIG)  
Ameritas  
AVIVA (AmerUs)  
AVS  
AXA  
Banner Life Insurance Company  
Columbus Life  
Coventry Financial  
Coventry First  
Credit Suisse Life Finance Group  
EMSI  
Fasano Associates

First Global Financial & Insurance Services  
Indianapolis Life  
Integrated Financial Solutions, LLC.  
John Hancock Life  
Life Style Insurances Services, Inc.  
Life Distributors of America  
Life Insurance Settlements, Inc. (LIS)  
Lincoln Benefit Life  
Lincoln Financial Group  
Maple Life Financial, Inc.  
Massachusetts Mutual  
Metropolitan Life  
New York Life  
North American  
Old Mutual Financial Network  
Pacific Life

Penn Mutual  
Phoenix Life  
Presidential Life  
Principal Financial  
Protective Life  
Prudential Life  
ING/ReliaStar Life of NY  
ING/ReliaStar/Security Life of Denver  
Sun Life Insurance Co. of America  
Sun Life Insurance Co. of Canada  
The New England  
Transamerica  
USFL Insurance Co.  
Union Central Life  
Welcome Funds, Inc.  
West Coast Life

**INSTRUCTIONS TO AGENT: THE NOTICE BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE. AIN—GRAMM LEACH BLILEY DISCLOSURE**

The personal information you provided in this Policy Audit & Analysis Form may be protected from disclosure under Federal and State law. Certain financial institutions, such as those that engage in insurance, securities or banking, are required to inform you as to how they will maintain your non-public personal information. Financial institutions must tell you about their privacy practices at certain times, such as when you purchase a financial product and once a year thereafter. Your insurance agent or financial advisor will be able to share with you information concerning the privacy policies of the financial institutions they represent.

**NOTICE OF INSURANCE INFORMATION PRACTICES**

This is to inform you that as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access this information upon written request. You may request correction, amendment, or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance, you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient to you. In the event you are not in when the interviewer calls, the interviewer will leave his/her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and telephone number of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112 Telephone: 617-426-3660

The Company, or its reinsurers, may also release information in its file 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.

**AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION**  
**HIPAA COMPLIANT**

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Name of Proposed Insured/patient (Please type or print)

Date of Birth

I **authorize** any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, 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, prescription history, medications prescribed, and any other protected health information concerning me to the insurance companies and/or settlement companies named below. 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 to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

**This protected health information** is to be disclosed under this Authorization so that the insurance companies and/or settlement companies named below 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 insurance and/or settlement companies named below.

**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 providing written notification to the Office of the President of Advantage Insurance Network, Inc. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that the insurance and/or settlement companies named below 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 is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies and/or settlement companies named below except as authorized by me or as required by law.

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 or release my complete medical record, the insurance and/or settlement companies named below may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Aaron Advantage Agency, Inc.	Integrated Financial Solutions, LLC.	Penn Mutual
Advantage Insurance Network, Inc.	John Hancock Life	Phoenix Life
Advanced Settlements, LLC	Life Style Insurance Services, Inc.	Presidential Life
Allianz	Life Distributors of America	Principal Financial
American General Life (AIG)	Life Insurance Settlements, Inc. (LIS)	Protective Life
Ameritas	Lincoln Benefit Life	Prudential Life
AVIVA (AmerUs)	Lincoln Financial Group	ING/ReliaStar Life of NY
AVS	Maple Life Financial, Inc.	ING/ReliaStar/Security Connecticut Life
AXA	Massachusetts Mutual	ING/Security Life of Denver
Banner Life Insurance Company	Metropolitan Life	Sun Life Insurance Co. of America
Columbus Life	New York Life	Sun Life Insurance Co. of Canada
Coventry Financial	North American	The New England
Coventry First	Old Mutual Financial Network	Transamerica
Credit Suisse Life Finance Group	John Hancock Life	USFL Insurance Company (CA Only)
EMSI	Life Style Insurance Services, Inc.	Union Central Life
Fasano Associates	Life Insurance Settlements, Inc. (LIS)	Welcome Funds, Inc.
First Global Financial & Insurance Services	Lincoln Benefit Life	West Coast Life
Indianapolis Life	Pacific Life	21 <sup>st</sup> Services, LLC.

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Signature of Proposed Insured/Patient or Personal Representative

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Date

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Description of Personal Representative's Authority or Relationship to Patient