

# J. L. THOMAS & COMPANY, INC.

## Life Brokerage Agency

COMPLETE APPLICABLE STATEMENT BELOW ONLY IF DIABETIC OR CARDIAC CASE

### APPLICANT'S DIABETIC QUESTIONNAIRE

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight two years ago \_\_\_\_\_ Date diabetes diagnosed \_\_\_\_\_

Name and address of doctor who made the diagnosis \_\_\_\_\_

Are you receiving treatment or under medical supervision now? \_\_\_\_\_

Give name and address of doctor \_\_\_\_\_

Do you ever stop the insulin or go off diet? \_\_\_\_\_ Is urine sugar free: (a) Now? \_\_\_\_\_ (b) Always? \_\_\_\_\_ (c) Date of last test? \_\_\_\_\_

Have you had any blood sugar estimations done? \_\_\_\_\_ If so, when, and what were the fasting estimations? \_\_\_\_\_

State amount of insulin taken daily \_\_\_\_\_ units \_\_\_\_\_

Type: Regular or Plain \_\_\_\_\_ units \_\_\_\_\_ Globin \_\_\_\_\_ units \_\_\_\_\_

Protamine Zinc \_\_\_\_\_ units \_\_\_\_\_ Time of administration \_\_\_\_\_

Have you ever had any infections, such as boils, abscessed teeth, tonsillitis, etc? \_\_\_\_\_

Specify \_\_\_\_\_

Have you ever had any eye trouble? \_\_\_\_\_ Have you ever had any high blood pressure? \_\_\_\_\_

Have you ever had any heart trouble? \_\_\_\_\_ Have you ever had any recurring or prolonged illness? \_\_\_\_\_

Has an electrocardiogram been taken \_\_\_\_\_ Date \_\_\_\_\_

By whom? \_\_\_\_\_

If cardiogram taken, please submit same. It will be returned. \_\_\_\_\_ Was the electrocardiogram reported normal? \_\_\_\_\_

Has an x-ray of the chest been taken \_\_\_\_\_ Date \_\_\_\_\_

By whom? \_\_\_\_\_

Was the x-ray reported normal? \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

### APPLICANT'S CHEST PAIN QUESTIONNAIRE

(Please enclose all available Electrocardiogram tracings)

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residence Address \_\_\_\_\_

- |  |                          |                          |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
|--|--------------------------|--------------------------|----|----------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---|--|-----|----|---------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|---|--|-----|----|-----------------------|--------------------------|--------------------------|------------------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|
| <p><b>A. Have any of the following ever been experienced:</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>1. Chest Pain?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Palpitation?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Shortness of Breath</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>4. Other Chest Discomfort?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> |                          | YES                      | NO | 1. Chest Pain? | <input type="checkbox"/> | <input type="checkbox"/> | 2. Palpitation? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Shortness of Breath | <input type="checkbox"/> | <input type="checkbox"/> | 4. Other Chest Discomfort? | <input type="checkbox"/> | <input type="checkbox"/> | <p><b>B. Did Chest Pain involve:</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>1. Middle of Chest?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Left side of Chest?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Left Shoulder, Arm or Hand?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>4. Both Shoulders or Arms?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>5. Sense of Pressure or Constriction?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> |  | YES | NO | 1. Middle of Chest? | <input type="checkbox"/> | <input type="checkbox"/> | 2. Left side of Chest? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Left Shoulder, Arm or Hand? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Both Shoulders or Arms? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Sense of Pressure or Constriction? | <input type="checkbox"/> | <input type="checkbox"/> | <p><b>C. Was it associated with:</b></p> <table border="0"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>1. Exertion? Exercise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>2. Excitement? Strain?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>3. Meals?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> |  | YES | NO | 1. Exertion? Exercise | <input type="checkbox"/> | <input type="checkbox"/> | 2. Excitement? Strain? | <input type="checkbox"/> | <input type="checkbox"/> | 3. Meals? | <input type="checkbox"/> | <input type="checkbox"/> |
|  | YES                      | NO                       |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 1. Chest Pain?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 2. Palpitation?  | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 3. Shortness of Breath   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 4. Other Chest Discomfort?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
|  | YES                      | NO                       |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 1. Middle of Chest?  | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 2. Left side of Chest?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 3. Left Shoulder, Arm or Hand?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 4. Both Shoulders or Arms?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 5. Sense of Pressure or Constriction?  | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
|  | YES                      | NO                       |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 1. Exertion? Exercise  | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 2. Excitement? Strain?   | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |
| 3. Meals?  | <input type="checkbox"/> | <input type="checkbox"/> |    |                |                          |                          |                 |                          |                          |                        |                          |                          |                            |                          |                          |   |  |     |    |                     |                          |                          |                        |                          |                          |                                |                          |                          |                            |                          |                          |                                       |                          |                          |   |  |     |    |                       |                          |                          |                        |                          |                          |           |                          |                          |

- D. If any of the above answered "yes," complete the following questions:**
- |  |   |
|--|---|
| 1. Approximate date of first pain? _____     | 8. Date of return to work? Restrictions? _____                    |
| 2. Date of last pain? _____                  | 9. What medicine is taken now? _____                              |
| 3. How frequently did the pains occur? _____ | 10. When was the last Electrocardiogram taken? _____              |
| 4. Duration of pains? _____                  | By whom? _____  |
| 5. Hospitalized? How long? _____             | 11. What diagnosis was made concerning the heart condition: _____ |
| 6. Confined at home? How long? _____         | _____   |
| 7. Convalescent? How long? _____             | _____   |

**E. Give names and addresses of all physicians consulted** \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

## Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize (J.L. THOMAS & CO.) 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 (J.L. THOMAS & CO.). 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 (J.L. THOMAS & CO.) 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, (J.L. THOMAS & CO.) 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, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, ING USA Annuity and Life Insurance Company, John Hancock, Lincoln Benefit Life, 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, 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, Security Life of Denver Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, West Coast Life Insurance Company