



J. L. THOMAS & COMPANY, INC.

Life Brokerage Agency



1500 Chester Avenue • Cleveland, Ohio 44114 • 216/241-2300 • Toll Free 800/222-4090

JERRY L. THOMAS, CLU
President

CRAIG W. THOMAS
Vice President Operations

J. MICHAEL THOMAS, CLU
Vice President Marketing

DAVID D. THOMAS, CLU ChFC
Vice President Marketing

JAMES X. KELLY
Brokerage Sales

INFORMAL INSURABILITY INQUIRY Minimum Consideration: \$50,000

PLEASE COMPLETE ALL QUESTIONS IN FULL

IF DIABETIC OR CARDIAC CASE, PLEASE COMPLETE APPROPRIATE FORM ON REVERSE SIDE.

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FULL NAME (PRINT)		PLAN OF INSURANCE <input type="checkbox"/> ADB <input type="checkbox"/> WP	AMOUNT DESIRED \$
DATE OF BIRTH	PLACE OF BIRTH	BENEFICIARY (Name and Relationship)	
RESIDENT ADDRESS		HOW MUCH INSURANCE IN FORCE NOW? \$	
MARRIED <input type="checkbox"/>	SINGLE <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>
OCCUPATION _____		HEIGHT: _____ Ft. _____ Inches	WEIGHT: _____ Lbs.
EMPLOYER _____		Has case been submitted to other companies in past 6 mos.? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list companies and dates submitted.	
ADDRESS _____			

LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:

Name of Company	Amount	Year	Declined?	Issued?	Extra Premium	Reason Rated or Declined

	NAME AND ADDRESS	REASON	DATE
What physician did you last consult? (Other than insurance examination)			
What physicians have you consulted during the past 10 years?			
In what hospitals, clinics, or sanitariums have you ever been treated?			
Who is your personal physician? When did you last consult him?			

HAVE YOU SMOKED ANY TOBACCO PRODUCTS IN THE PAST 12 MONTHS? Yes No

What kind and how much? _____

IS THIS INQUIRY TO REPLACE EXISTING COVERAGE? Yes No

REMARKS:

Agent _____

Address _____ Tel. No. () _____

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Life Insurance Companies listed on this form at the time of my signature any such information. A photographic copy of this authorization shall be valid as the original.

We represent:

- | | | | | | | |
|-------------------|-----------------------------|-----------------------------------|----------------------------------|--------------------------|----------------------------------|--------------------|
| Aetna
AIG Life | Banner Life
First Colony | First Penn-Pacific
GeneralLife | Life of Virginia
Metropolitan | Prudential
State Life | Union Central
United of Omaha | Zurich Kemper Life |
|-------------------|-----------------------------|-----------------------------------|----------------------------------|--------------------------|----------------------------------|--------------------|

Veterans Administration Case No. _____

I have received the Notice of Exchange of Information and Fair Credit Act.

C — _____ Date _____ Proposed Insured MUST Read Authorization and Sign _____