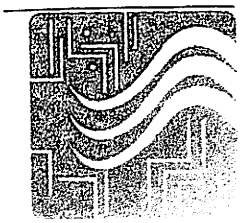
Informal Inquiry Form

Not an application for Life Insurance



WMR INSURANCE MARKETING

1) AGENT / PRINCIPAL INFORMATION

Name_____ Social Security #_____ Phone #_____ Fax #_____

Address_____ City_____ State_____ Zip_____

Corporate Name_____ Primary Company_____ Tax ID #_____

2) PERSONAL HISTORY OF INSURED(S) - Please Use A Separate Form For Each Proposed Insured

Primary Insured_____ M / F _____

Social Security # _____ Phone _____

Address_____ City_____ State_____ Zip_____

DOB_____ Age_____ Height_____ Weight_____ Annual income_____ Estate Size_____

Have you smoked cigarettes in past 12 months Yes/ No____ Have you ever used tobacco in other form Yes/ No___ Date_____

Occupation_____ What are your duties _____

Special Risk Underwriting Considerations _____

Cell Phone_____ Drivers license number_____

Secondary Insured_____ M / F _____

Social Security # _____ Phone _____

Address_____ City_____ State_____ Zip_____

DOB_____ Age_____ Height_____ Weight_____ Annual income_____ Estate Size_____

Have you smoked cigarettes in past 12 months Yes/ No____ Have you ever used tobacco in other form Yes/ No___ Date_____

Occupation_____ What are your duties _____

Special Risk Underwriting Considerations _____

Drivers license number_____ Cell Phone_____

999 Tyner Way
P.O. Box 6421
Incline Village, NV 89451-6421
Phone 818-802-6222
Fax 866-713-1567
Email: wendy@wmrinsurance.com

3) PLAN OF INSURANCE DESIRED

UL _____ VUL_____ Term _____ Term # of years _____ ART_____ WL _____ SURV UL _____ SURV VAR _____

Face amount $_____ Premium desired $_____ 1035/Lump sum $_____

Purpose of Insurance: Business _____ Personal _____

Beneficiary _____ Owner _____

4) OFFERS BY OTHER COMPANIES

Company_____ Date(s) _____ Amount $_____

_____

Action(s) _____

_____ Premium Amount Desired $_____

Is this case currently being considered by another impaired risk agency Yes /No _____

5) CURRENT INSURANCE COVERAGE

Total amount in force_____ Date of last application_____ Is this replacement Yes/ No

Name of Company_____ If so, premium being replaced $_____

6) FAMILY HISTORY

Primary	Age if Living	Age of Death	Cause of Death
Mother			
Father			
Sibling			
Sibling			
Secondary	**Age if Living**	**Age of Death**	**Cause of Death**
Mother			
Father			
Sibling			
Sibling			

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Detailed information is required.

7) **MEDICAL INFORMATION / COMMENTS** (USE ADDITIONAL PAGES IF NECESSARY)

Primary Insured

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

Secondary Insured

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

Diagnosis _____ Date of Diagnosis _____

Medications & Dosage _____

Treatment _____

_____

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8) PHYSICIANS INFORMATION

Name			
Specialty			
Street			
City			
State			
Zip			
Phone			

Name			
Specialty			
Street			
City			
State			
Zip			
Phone			

Name			
Specialty			
Street			
City			
State			
Zip			
Phone			

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Authorization to obtain information

Name_____ **Date of birth**_____

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give the Insurance Companies named below any and all such information. To facilitate rapid submission of such information, I authorize all said sources, except The Medical Information Bureau, Inc. to give such records or knowledge to WMR Insurance Marketing/WMR, Inc

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I UNDERSTAND WMR Insurance Marketing/WMR Inc. will use the information obtained by use of this Authorization and/or the Insurance Companies named below to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by WMR Insurance Marketing/WMR Inc. or the Insurance Companies named below to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, life expectancy evaluation or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

Insurance Companies

Allianz Life Insurance Company of New York
American General Life
Accordia-Global Atlantic
American National Insurance Company
Banner Life
First Met Life Investors Insurance Company
John Hancock Life Insurance Company of NY
Lincoln Financial Group
Columbus Life
Mass Mutual
Mutual of Omaha
New York Life
Pacific Life
Principal Life Insurance Company
Protective Life & Annuity Insurance Company
Symetra Life
Transamerica Life Insurance Company
William Penn Insurance Company of NY
United of Omaha

Allianz Life Insurance Company of No.America
Lincoln National
Sagicor Life
AXA-Equitable
Companion Life Insurance Company
John Hancock (USA)
Life of the Southwest
Lincoln Life and Annuity of NY
Brighthouse
Minnesota Life
Nationwide
North American Life and Health
Penn Mutual
Principal National Life Insurance Company
Prudential Financial
Transamerica Financial Life Insurance Company
United States Life Insurance of NY
Zurich American Life Insurance Company

Additional
Companies:_____

Other Entities

21st Services
Brokers Alliance
AUS Underwriting
ISC Services
Life Insurance Settlements
IBU
Abacus Life Settlements
American Viatical Services
Fasano Associates
3Mark Financial
Professional Underwriting Services
Welcome Funds, Inc.
Underwriting Services of America
Express Imaging Services/ EIS Processing Center P.O. Box P Torrance, CA 90508

I KNOW that I may request to receive a copy of this Authorization.
I AGREE this Authorization shall be valid for two years from the date shown below.
Signed this_____ day of _____, 20_____

X _____
Signature of Proposed Insured/Parent or Guardian

_____
Printed name of Proposed Insured/Parent or Guardian

_____ _____
Date of Birth Social Security Number

_____ _____
Medical records requested from Medical Facility or doctor
Date range of records request

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