TOLER & TOLER
INSURANCE SERVICES, LLC

BASIC DATA NEEDED

Insured Name:			
Home Address:			
Years at address:			
Home Telephone:		Mobile:	
eMail Address:			
SSN#:			
Date of Birth:			
Occupation:			
Birthplace (City/State)			
Height:		Weight:	
Employer:			
Address:			
Primary Beneficiary:			
Date of Birth:		SSN#:	
Primary Beneficiary Relationship:			
Contingent Beneficiary:			
Date of Birth:		SSN#:	
Contingent Beneficiary Relationship:			

1564 State Route 160 • Gallipolis, Ohio 45631
Phone: (740) 446-9445 • Fax (740) 446-7082 • TF (800) 562-2646 • www.tolerins.com

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BASIC DATA NEEDED(cont'd)

Requested Death Benefit:	
INSURED INFORCE INSURANCE AND/OR PENDING APPLICATIONS ON ALL POLICIES FOR INSURED AND OWNER	

INSURED NAME	COMPANY	POLICY NUMBER	YEAR ISSUED	FACE AMOUNT	BUSINESS or PERSONAL

OWNER/APPLICANT

Annual income from work:	
Job Title:	
Other Income:	
Net Worth:	

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UNDERWRITING DATA NEEDED

INSURED ONLY

Current Physician Name:	
Address:	
Phone:	
Current Prescription Drugs:	
Date of last doctor visit and result:	

EVER HAD:

Cancer:		Type:	
Heart Disease:		Type:	
Leukemia:			
HIV Positive:			
Current Exercise Program:			
HEALTH HISTORY SUMMARY INCLUDING ALL HOSPITALIZATIONS, PHYSICALS, DATES, NAMES, AND ADDRESSES OF ALL DOCTORS SEEN OTHER THAN CURRENT PHYSICIAN:			

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UNDERWRITING DATA NEEDED(cont'd)

Drivers License #:		State:	
Issue Date:		Expiration Date:	
Accidents or Tickets in the past 3 years?:			

Tobacco in any form:		Type:	
Current Use:		Amount:	
Date Stopped Use:			
Alcohol:		Type(s):	
Current Use:			
Date Stopped Use:			
Drugs:		Type(s):	
Current Use:		Amount:	
Date Stopped Use:			

Ever Flown as Pilot:		Dates:	
Scuba Diver/Any other hazardous activities:		Dates:	
Has any family member been diagnosed with any heart disease, cancer, etc?:			

	IF LIVING Age/State of Health	**IF DECEASED Cause/Age at Death**
Father:		
Mother:		
Brothers:		
Sisters:		

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Authorization

to Obtain and Disclose Confidential Information

LION STREET®

This Authorization is HIPAA compliant.

Proposed Insured: _____

Date of Birth: _____ Social Security #: _____

Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Lion Street, Inc., Lion Street Financial, LLC, Lion Street Advisors, Inc., Lion Street Insurance Services, Inc., Tellus Brokerage, Inc., Crump Life Insurance Services, Inc., brokers, contractors, employees, representatives and agents working for or through those entities for purposes of the Proposed Insured applying for or evaluating insurance coverage.

21st Services	Mutual of Omaha
Abacus Life	National Life of Vermont
AIG	Nationwide Life and Annuity Co. of America
Allianz of North America	New England Life Insurance Co.
American General Life Insurance Co.	New York Life Insurance and Annuity Co.
American National	New York Life Insurance Co.
Ashar Group, LLC	North American Co.
Banner Life	One America/State Life
Better Health Advisors	Pacific Life and Annuity Co.
Brighthouse Financial	Pacific Life Insurance Company
Companion Life	Pan-American Assurance Company
Continental Assurance (CNA) LTC	Pan-American Life Insurance Group
Crown Global Insurance Group, LLC	Penn Insurance and Annuity Company
Crump Life Insurance Services, Inc.	Penn Insurance and Annuity Company of New York
Disability Insurance Services, Inc.	Penn Mutual Life Insurance Company
Equitable Financial Life Insurance Company	Peterson International Underwriters
Equitable Financial Life Insurance Company of America	Phoenix Life Insurance Co.
Equus Financial Consulting, LLC	Phoenix Variable Ins. Co
ExamOne	Principal Financial
ExamOne Superior Solutions	Principal Life Insurance Company
Exceptional Risk Advisors	Principal National Life Insurance Company
Exclusive Marketing Organization (EMO)	Pro Offer (Risk Righter, LLC)
Fasano Associates, Inc.	Protective Life Insurance Co.
Genworth Life and Annuity	Protective of NY
Genworth Life Insurance Co.	Pruco Life Insurance Co.
Genworth Life of New York	Pruco Life Insurance Co. of New Jersey
Global Atlantic Financial Group	Prudential Insurance Co. of America
Global Financial & Insurance Services	Prudential Life Insurance Companies
Great West Life	Resolution Life
Guardian Life	Securian Life Insurance Company
Hartford Life and Annuity Insurance Co.	Sun Financial
Hartford Life Insurance Co.	Sun Life Assurance Co. of Canada
Jetstream APS	Sun Life Insurance and Annuity Co. of NY
John Hancock Life U.S.A.	Sun Life Insurance Co. of America
John Hancock New York	Symetra Life Insurance Company
Legal & General America	Tellus Brokerage, Inc.
Life of the Southwest	TIAA -Cref
Lincoln Life	Transamerica Financial Life Insurance
Lincoln Life & Annuity Co. of New York	Transamerica Life Insurance Company
Lombard International	Union Central Insurance
M3 Financial	United of Omaha
Mass Mutual Life Insurance Company	United States Life
Mercury Financial Group	West Coast Life Ins Co.
Met Life	William Penn of New York
Met Life Investors USA Insurance	Zurich American Life Insurance Company
Minnesota Life Insurance Company	Zurich American Life Insurance Company of New York

Agent Name: _____ Physician(s): _____

Agency Name: _____ Facility/Hospital(s): _____

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any information and all records regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental & physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing & treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing & treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician, any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to the Insurers and Agencies listed afore.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed afore may use secured internet-based systems to store and access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ (city, state) this _____ day of _____, _____ (year)

Proposed Insured's Signature: _____

Print name of Proposed Insured: _____ Social Security #: _____

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child: _____

Relationship of Representative to Minor: _____

Signature of Witness: _____

Signature(s) of Policy Owner(s): _____

Notice to Proposed Insured

LION STREET®

Instructions to the Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning 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 others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they
may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

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

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.

EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.

TOLER & TOLER
INSURANCE SERVICES, LLC

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION
This authorization complies with the HIPAA Act and Privacy Rules

Name of Insured/Patient (please print):_____

Date of Birth _____
This authorization is for Release of Health-Related Information to the following:

Name. _____

Address. _____ City _____ State. _____ Zip _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, mental health .or substance abuse facility, or other Medical or medically related facility, insurance company, the Medical 'Information Bureau or other organization, institution or person that has provided payment, treatment or services to me or on my behalf to disclose my entire medical record an any other protected health information concerning me to Toler & Toler Insurance Services, LLC and its agents, employees, and representatives. This includes information on the diagnosis 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.

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 Toler & Toler Insurance Services, LLC 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 Toler.& Toler Insurance Services, LLC.

This authorization shall remain in force for 30 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 sending a written request for revocation to Toler & Toler Insurance Services; LLC, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My providers has relied on this Authorization or to the extent that Toler & Toler Insurance Services, LLC has 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 may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality or health information.

I understand that My Providers may not refuse to provide treat me for payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Toler & Toler Insurance Services, LLC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____

Signature of Proposed Insured/Patient or Personal Representative Date

_____

Description of Personal Representative's Authority or Relationship to Patient

_____

Agent Signature Date

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