ELITE MARKETING GROUP
INSURANCE DESIGNERS

800 Bering Drive #105 ♦ Houston, TX 77057 ♦ 713-507-1011 ♦ FAX 713-507-1090
12466 Los Indios Trail, Suite #100 ♦ Austin, TX 78729 ♦ 512-257-9700 ♦ FAX 512-257-9701

ADVISOR NAME:

_____

Phone # (_____)

DEATH BENEFIT/FACE AMOUNT:

TERM - $_____

PERM - $_____

INFORMAL INQUIRY

Not an application for insurance

FULL NAME:	**SEX:**	**DOB:**	**DL # / EXP DATE & STATE:**	**SSN:**

PRESENT ADDRESS:	**OCCUPATION & DUTIES:**

USE ANY FORM OF TOBACCO? (Cigarettes, pipe, cigars, dip or chewing tobacco) **YES** **NO**
If yes, list type & amt or date quit:

1. **Have you been hospitalized for any reason in the last 5 years?** **YES** **NO**
   Advise reason, length of stay and any treatment/medications given as well as follow up completed and/or recommended.
   Details: _____
2. **Are you currently taking any prescription medications?** **YES** **NO**
   Please provide name, dosage and frequency of all prescribed medications.
   Details: _____
3. **Any family history of diagnosis, treatment or death due to heart disease or cancer?** **YES** **NO**
   Please provide whether a parent or sibling, condition and age at diagnosis or death.
   Details:_____

LIST ALL DOCTORS – NAME & ADDRESS	**DR PHONE #**	**DATE LAST SEEN & REASON FOR VISIT ANY TREATMENT OR MEDICATION PRESCRIBED**

AUTHORIZATION TO OBTAIN INFORMATION

Please furnish: Insurance Designers of Houston, Allianz, American General, American National, Accordia, AXA Equitable, Banner Life, Cincinnati Life, Columbus Life, Global Atlantic, John Hancock, Lincoln Financial, MetLife, Minnesota Life, North American, Nationwide, New York Life, Pacific Life, Principal Life, Protective Life, Prudential, SBLI, Symetra, Transamerica, United of Omaha; Voya; Zurich; or their legal representative and reinsurers any information.

Information regarding your insurability will be treated as confidential.

The Companies named above may also release file information to other life insurance companies where you may apply for life or health insurance, or to whom a claim may be submitted. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health, to give to the companies named above any such information. A photographic copy of the authorization shall be as valid as the original. By my signature, I indicate that I retained a copy of this information.

X

_____ _____ _____

Signature of Proposed Insured **Printed Name of Proposed Insured** **Date**

Proposed Insured Preferred Phone Number: (_____)_____