

Questionnaire/Informal Inquiry

Please Print

Name: _____ Date of Birth: _____

Place of Birth: (City & State) _____ U.S. citizen? Yes _____ Other (specify) _____

Social Security Number: _____

Spouse: _____ Date of Birth: _____

Children (Names and Ages) : _____

Grandchildren (Names and Ages): _____

Home Address: _____

Home Phone Number: (____) _____ Cell Phone Number: (____) _____

e-mail address: _____

Employer: _____

Business Address: _____

Business Phone Number: (____) _____ Business Fax Number: (____) _____

Name of Assistant: _____ Asst. Phone/e-mail: (____) _____

Annual earned income from your occupation for federal tax purposes (After business expenses, if any):

Salary \$ _____

Other \$ _____ Describe: _____

Unearned income (interest, dividends, capital gains, etc.) \$ _____

Describe unearned income: _____

Net Worth \$ _____

Height: _____ Weight: _____ lbs.

Do you currently use: Cigarettes - Yes _____ No _____ Cigars - Yes _____ No _____ Other - Yes _____ No _____

If yes for Cigars, frequency/quantity _____ If yes for Other, provide details _____

If no for Cigarettes, years/months last smoked (if less than 3 years) _____

Upon completion, please fax or e-mail to Beacon Wealth Consulting, LLC at the fax number or address above.
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Life insurance currently in force:

<u>Company</u>	<u>Policy Number</u>	<u>Year of Issue</u>	<u>Type of Insurance</u>	<u>Personal or Business</u>	<u>Death Benefit</u>	<u>Cash Value</u>	<u>Annual Premium</u>
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Is life, disability or long-term care insurance contemplated or being currently applied for? Yes _____ No _____

If yes, details: _____

Will this insurance being applied for replace any of the above? Yes _____ No _____ (Circle it above)

Have you ever been declined, postponed, rated or offered a policy other than applied for? Yes _____ No _____

If yes, give details: _____

Do you have plans to travel or residence outside the U.S.A.? Yes _____ No _____

If yes, give details: _____

Have you ever flown, in the past two years, in any aircraft other than as a passenger? Yes _____ No _____

If yes, give details: _____

Do you participate in any regular physical exercise program? Yes _____ No _____

If yes, give details: _____

In the past five years have you been in a motor vehicle accident or charged with a moving violation of any motor vehicle law or had your license revoked? Yes _____ No _____

If yes, give details: _____

Driver's license state/number: _____ Expiration Date: _____

Have you ever engaged in or contemplated engaging in parachuting, racing, underwater diving or any hazardous sport or hobby? Yes _____ No _____

If yes, give details: _____

Will the policy be trust owned? Yes _____ No _____

If so, what is the state situs of the trust? _____

Signature: _____

Date: _____

NOTICE TO PROPOSED INSURED(S)

Instructions to the Agent: This form 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.

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The insurers named on the reverse side or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information they may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, Massachusetts 02112; Phone (617) 426-3660.

Each named insurer or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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. I authorize 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 REQUIRES THE COMPLETION OF A FULL APPLICATION FOR ITS RESPECTIVE PRODUCT LINES.

HIPAA COMPLIANT AUTHORIZATION TO OBTAIN & DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Proposed Insured: _____

Date of Birth: _____ Social Security Number: _____

Records and Information obtained will be disclosed between the insurance company or companies listed below, and Windsor Insurance Associates, Inc. producers, contractors, employees, representatives and affiliates.

INSURERS

Advanced Settlements	First Bank of Delaware	PFG
AI Credit	Genworth Life Insurance Companies	Phoenix Home Life
Allianz	Goldman Sachs	Polaris Capital
American General Life Companies	Guardian Life	Potomac Partners
American National	Hartford Life Insurance Companies	Principal Financial Group
Ameritas (for SPIA products only)	Highland Capital Brokerage	Principal Life Insurance Company
AVS	ING Life Insurance Companies	Principal National Life Insurance Co.
Aviva USA	InsCap	Protective Life Insurance Companies
AXA Equitable Life	Institutional Life Services, LLC	Prudential Life Insurance Companies
Bankers Life of New York	Insurative	Ridge Capital
Banner Life	John Hancock Life Insurance Companies	Sun Life Insurance Companies
Bragg	Liberty (for SPIA products only)	21 st Services
Brokerage Services, Inc.	LifeStyle Settlement, Inc.	Total Financial & Insurance Services
C2 Advisors	Lincoln Benefit Life	Transamerica Life Insurance Companies
Cambridge Financing Company (CFC)	Lincoln National Life Insurance Companies	Union Central
Centara Capital Management Group, Inc	Longmore Credit	United National Funding
CMS	Metlife Life Insurance Companies	United of Omaha
Companion Life	Minnesota Life	Universal Insurance Services
Concord Capital	Mutual of Omaha	US Life
Coventry First	Nationwide Insurance Company	West Coast Life
Credit Suisse	New York Life Insurance Companies	William Penn
EquityKey Real Estate Option, LLC	NIW	Windsor Insurance Associates, Inc.
F&G Life	North American Company	
Fasano	Pacific Life	

The purpose of this disclosure is to evaluate my application for insurance. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, (5) STD testing and treatment, (6) Genetic testing, (7) Sickle Cell testing and treatment, (8) lab results; (9) other insurance coverage (10) hazardous activities; (11) character; (12) general reputation; (13) mode of living; (14) finances; (15) occupation; and (16) other personal traits.

I understand that any Insurer named above, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect information for proposed insurance coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records, custodians, or anyone else located at:

Medical Facility: _____

Facility Address: _____

To release any and all records and information regarding the Proposed Insured listed above to and exchanged between the parties listed above and:

Requestor of Medical Information: _____

Requestor Address: _____

Broker/Agent/Agency/Firm: Beacon Wealth Consulting, LLC

Broker/Agent/Agency/Firm Address: 105 Rowayton Ave, Rowayton, CT 06853

The Insurers named above and their reinsurers will use the information in order to determine whether I am insurable. The insurance producer may also use this information to help update and improve my insurance program.

Those parties named above may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) MIB; or (4) other persons who perform business, professional or insurance tasks for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use a secured internet-based system to store/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 same rule that applied in the first instance. This authorization will remain in effect for 36 months from the date of my signature below. I understand I may revoke this Authorization at any time by requesting such of my broker in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. 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). My authorized representative may receive a copy of this Authorization. If minor children are proposed for coverage, the above statements are made by their 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 _____ this ____ day of _____, (year)_____.

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative:

Signature of Witness: _____

Complete if minor child is proposed for coverage:

Name of Minor Child: _____

Relationship of Representative to minor: _____



THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

Informal Inquiry
Revised as of October 2009