

Questionnaire/Informal Inquiry

Please Print

Name: _____ Male: ____ Female: ____

Date of Birth: _____

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

Social Security Number: _____

Spouse: _____ Date of birth: _____

Number of Dependents: _____ Name(s) of Dependents: _____

Residence 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.

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
 AI Credit
 Allianz
 American General Life Companies
 American National
 Ameritas (for SPIA products only)
 AVS
 Aviva USA
 AXA Equitable Life
 Bankers Life of New York
 Banner Life
 Bragg
 Brokerage Services, Inc.
 C2 Advisors
 Cambridge Financing Company (CFC)
 Centara Capital Management Group, Inc
 CMS
 Companion Life
 Concord Capital
 Coventry First
 Credit Suisse
 EquityKey Real Estate Option, LLC

F&G Life
 Fasano
 First Bank of Delaware
 Genworth Life Insurance Companies
 Goldman Sachs
 Hartford Life Insurance Companies
 Highland Capital Brokerage
 ING Life Insurance Companies
 InsCap
 Institutional Life Services, LLC
 Insurative
 John Hancock Life Insurance Companies
 Liberty (for SPIA products only)
 LifeStyle Settlement, Inc.
 Lincoln Benefit Life
 Lincoln National Life Insurance Companies
 Longmore Credit
 MetLife Life Insurance Companies
 Mutual of Omaha
 Nationwide Insurance Company
 New York Life Insurance Companies
 NIW

North American Company
 Pacific Life
 PFG
 Phoenix Home Life
 Polaris Capital
 Potomac Partners
 Principal Financial Life Ins, Co.
 Protective Life Insurance Companies
 Prudential Life Insurance Companies
 Ridge Capital
 Sun Life Insurance Companies
 21st Services
 Total Financial & Insurance Services
 Transamerica Life Insurance Companies
 Union Central
 United National Funding
 United of Omaha
 Universal Insurance Services
 US Life
 West Coast Life
 William Penn
 Windsor Insurance Associates, Inc.

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: _____

Broker/Agent/Agency/Firm Address: _____

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: _____