

Warner Financial Group Preliminary Inquiry

This is NOT an application for life insurance. It is a preliminary evaluation to assist in determining insurability only.

Client Information

Name of Insured: _____ Soc Sec #: _____ - _____ - _____ Date of Birth: ____ / ____ / ____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Gender: Male Female
Height: ____ ft. ____ in. Weight: _____ lbs Tobacco Use: Yes No If yes, type: _____ Date last used: _____
Occupation: _____ Employer: _____ Annual Income: \$ _____ Net Worth: \$ _____
Are you a US Resident? Yes No Are you a US Citizen? Yes No If either is No, what country? _____

Coverage Information

Face Amount \$ _____ Policy Type: Indiv Surv UL GUL WL VUL
Proposed Premium: \$ _____ Single Pay Term Years level: ____ ROP State of Issue: _____
Total insurance in-force now: \$ _____ Date last purchased: ____ / ____ / ____ Rated? Yes No
Will new insurance replace any in-force insurance? Yes No
Will this be a 1035 Exchange? Yes No If Yes, approximate exchange: \$ _____
Have you ever been declined or rated for insurance? Yes No If Yes, please provide details: _____

Medical Provider Information

Name of Primary Care Physician: _____ Date Last Consulted: ____ / ____ / ____ Reason: _____
Full Address: _____ City: _____ State: ____ Zip: _____ Phone: (____) ____ - ____
Current diagnosis and medications: _____
Name of Specialist: _____ Date Last Consulted: ____ / ____ / ____ Reason: _____
Full Address: _____ City: _____ State: ____ Zip: _____ Phone: (____) ____ - ____

General Questions (please check any items or activities from the list below that apply and provide details):

- | | |
|--|---|
| A. <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Heart <input type="checkbox"/> Angina <input type="checkbox"/> Stroke <input type="checkbox"/> HBP | F. <input type="checkbox"/> Personal bankruptcy |
| B. <input type="checkbox"/> Cancer <input type="checkbox"/> Location _____ | G. <input type="checkbox"/> Driving record <input type="checkbox"/> DWI/DUI <input type="checkbox"/> violations |
| C. <input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 Age at dx: ____ | H. <input type="checkbox"/> Private aviation |
| D. <input type="checkbox"/> Any other medical conditions including:
<input type="checkbox"/> mental/nervous <input type="checkbox"/> respiratory <input type="checkbox"/> urinary <input type="checkbox"/> gastrointestinal | I. <input type="checkbox"/> Hazardous avocations: _____ |
| E. <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse | J. <input type="checkbox"/> Travel or residence outside the US or Canada |
| | K. <input type="checkbox"/> Other |

Details (A-K):

Agent/Financial Advisor To Complete This Section

Agent/Advisor Name: _____ SSN: _____ - _____ - _____ Email: _____
Firm: _____ Branch City: _____ Business Phone (____) ____ - ____
Licensed in: Residence state of insured Yes No Owner State Yes No Trust State Yes No

Warner Financial Group

Authorization to Obtain Information/ Waiver and Acknowledgment Form

AUTHORIZATION:

I AUTHORIZE any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Warner Financial Group and its agents, employees, and representatives. This includes information on the diagnosis or treatment of AIDS/ 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, but excludes psychotherapy notes.

By signing below, I am amending any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so that Warner Financial Group may: 1) underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below.

Aetna Life	Cologne Life Reinsurance Co.	Interstate Assurance	Penn Mutual
AIG Life	Colorado Bankers	Jefferson Pilot	Penn Treaty
Allianz	Companion Life	John Hancock	Physicians Mutual
Allmerica Financial	Coventry Financial	Life of Virginia	Principal Life
AIG/American General	National Life	Life Settlement Alliance	Protective Life
American Investors	Equitable of Iowa	Lincoln Benefit Life	Prudential
American Life & Casualty	Fidelity & Guarantee	Lincoln National	Warner Financial Group
American Mayflower	Fidelity Security	Lincoln National Rein. Co.	Security-Connecticut
American National	First Colony	Manulife	Southland Life Ins Co.
	First Penn Pacific		
AVIVA Life	Fortis	Mass Mutual	State Life
Banner Life	GE Capital	MONY Life Insurance Co.	Sun Life of Canada
BMA/RBC Life Ins Co	Genworth	Mutual of Omaha	Transamerica
Canada Life	Hartford Life & Annuity	NACOLAH	Travelers
Central National		National Guardian	United of Omaha
Citizens Security	Illinois Mutual	New York Life	US Financial
Clarica	ING Reliastar	Old Mutual Financial	West Coast Life
CNA LTC	ING Southland Life	Old Republic	Western Reserve Life
:CNA/Valley Forge	ING USG	Pacific Mutual	Zurich Life

This authorization shall remain in force for 24 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 Warner Financial Group, 30 Winding Way, Bernardsville, NJ 07924, Attention: Privacy Official. I understand that a revocation is not effective if any of My Providers has relied on this authorization or has to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be rediscovered and no longer covered by certain federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT:

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of Warner Financial Group, its successors, assigns, shareholders, directors and employees (collectively "WFG"). Applicant acknowledges, understands and agrees as follows:

- that Applicant has filed an application with WFG intending to secure life insurance from one or more insurance underwriters.
- that, in the course of applying for life insurance coverage, WFG has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- that WFG will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- that WFG maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- that WFG will use the Interchange to store some or all of the confidential and personal information Applicant has provided to WFG, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- that, even though WFG has in place security measures WFG believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though WFG will continue to upgrade those security measures from time to time as circumstances warrant, WFG can make no guarantee as to WFG's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
- that WFG cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
- that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in WFG's possession and/or stored on the Interchange.
- that Applicant will indemnify WFG for all costs and expenses incurred by WFG or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I **ACKNOWLEDGE** that I have received a copy of this document. I **AGREE** this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: _____ / _____ / _____

City: _____ State: _____

XX Signature of Proposed Insured/Parent or Guardian

Signature of Witness _____

Printed name of Proposed Insured/Parent or Guardian