First Look
Preliminary Inquiry for Insurance
**PERSONAL HISTORY**

<table>
<thead>
<tr>
<th>Name (First, MI, Last)</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Current Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Driver’s License Number / State</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Annual Earned Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duties</th>
<th>Net Worth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**REQUESTED PLAN OF INSURANCE**

Minimum consideration $500,000 death benefit and $5,000 premium

- Universal Life
- Whole Life
- Term, Level Period: ____________
- Survivorship*
- Long-Term Care
- Disability Income, Monthly Benefit: ________________

<table>
<thead>
<tr>
<th>Face Amount Desired</th>
<th>Premium Amount Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rate Class Desired</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

What is the purpose of the insurance?

<table>
<thead>
<tr>
<th>Name of Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

*If both have insurability questions - complete this form on each life.

**PENDING AND IN-FORCE COVERAGE**

- None

<table>
<thead>
<tr>
<th>Company</th>
<th>Issue or Application Date</th>
<th>Amount</th>
<th>Final Action/Risk Classification</th>
<th>Annual Premium</th>
<th>Replacement Planned?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

Outcome and offer from your primary carrier? _______________________________

Are you working with any other Impaired Risk Agencies on this case?  Yes: ____________ No: ____________

Has this case been discussed with anyone at Zenith Marketing Group, Inc.? Yes: ____________ No: ____________

Total amount to be accepted from all sources? ______________________________

Are there any carriers that should be excluded from consideration? Yes: ____________ No: ____________

Is the case being premium financed? Yes: ____________ No: ____________

Are you aware of any other information or special circumstances that would have an impact on Underwriting? Yes: ____________ No: ____________

**AGENT INFORMATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Fax Number</th>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**MEDICAL HISTORY**

Height: _____ feet _____ inches  
Weight: _____ pounds

Name, Address & Phone Number of Personal Physician

<table>
<thead>
<tr>
<th>Date Last Consulted</th>
<th>Reason Last Consulted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medication Prescribed  
Advice & Treatment Given

**OTHER MEDICAL TESTS**

<table>
<thead>
<tr>
<th>Test</th>
<th>Date(s)</th>
<th>Results</th>
<th>If abnormal, please provide details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td></td>
<td>Total: _____mg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cholesterol/HDL Ratio ____</td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
<tr>
<td>X-ray</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
<tr>
<td>Mammogram (women only)</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
<tr>
<td>Prostate Exam (men only)</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA) (men only)</td>
<td></td>
<td>Normal ☐</td>
<td>Abnormal ☐</td>
</tr>
</tbody>
</table>

Details of other medical tests and additional medical facilities consulted within the last 10 years.  
Provide dates, diagnosis, details, treatment, plus names, addresses & phone numbers for all physicians/medical facilities.
**CHEST PAIN - CORONARY**  ❑ Not Applicable

Date of diagnosis or first onset of symptoms: _____/_____/____

Heart Attack?  ❑ Yes, Date:___________  ❑ No

<table>
<thead>
<tr>
<th>Surgery:</th>
<th>Any symptoms post-operatively?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angioplasty, Date: <em><strong><strong>/</strong></strong></em>/____</td>
<td>❑ Yes ❑ No</td>
</tr>
<tr>
<td>Bypass, Date: <em><strong><strong>/</strong></strong></em>/____</td>
<td>❑ Yes ❑ No</td>
</tr>
<tr>
<td>Valve Replacement, Date: <em><strong><strong>/</strong></strong></em>/____</td>
<td>❑ Yes ❑ No</td>
</tr>
</tbody>
</table>

Number of diseased vessels: ______________________

Date of last Stress EKG: _____/_____/____

Results: ❑ Normal ❑ Abnormal: (provide details below)

Date of last Echocardiogram _____/_____/____

Results: ❑ Normal ❑ Abnormal: (provide details below)

Arrhythmias?  ❑ Yes (provide details)  ❑ No

Heart enlargement?  ❑ Yes (provide details)  ❑ No

**DIABETES**  ❑ Not Applicable

Date of Diagnosis: _________________________  Age at Diagnosis: ______

Treatment: ❑ Diet Only ❑ Oral Medication ❑ Insulin

Dosage and Details:

Blood Glucose Levels: Checked at home? ❑ Yes ❑ No

Results: __________________________

Frequency: __________________________

Last Glycohemoglobin level: _______ mg% (Hemoglobin A1c)

Date: __________________

Ever Had: Protein in urine? ❑ Yes ❑ No

Eye Trouble? ❑ Yes ❑ No

Heart Trouble? ❑ Yes ❑ No

High Blood Pressure? ❑ Yes ❑ No

Microalbumin in urine? ❑ Yes ❑ No

Kidney Trouble? ❑ Yes ❑ No

Neuritis or neuralgia? ❑ Yes ❑ No

Insulin Reactions? ❑ Yes ❑ No

**FAMILY HISTORY OF PROPOSED INSURED**

Have any immediate family members (parents, siblings) been diagnosed with or died from complications from circulatory disorders, heart disease, or cancer?

❑ Yes ❑ No

(If yes, please include details below)

<table>
<thead>
<tr>
<th></th>
<th>Age (if living)</th>
<th>Age at death</th>
<th>Onset age of disease</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
First Look
Preliminary Inquiry for Insurance

Proposed Insured: ___________________________  Social Security Number: _______________________

ZENITH MARKETING GROUP INC.

DRUG AND ALCOHOL USE

Do you currently drink alcohol?  ☐ Yes  ☐ No
Provide details below:

<table>
<thead>
<tr>
<th>Type:</th>
<th>Amount Per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer</td>
<td></td>
</tr>
<tr>
<td>Wine</td>
<td></td>
</tr>
<tr>
<td>Liquor</td>
<td></td>
</tr>
</tbody>
</table>

Did you ever drink substantially more than you do at the present time?  ☐ Yes  ☐ No
Provide details below:

<table>
<thead>
<tr>
<th>Type:</th>
<th>Amount Per Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beer</td>
<td></td>
</tr>
<tr>
<td>Wine</td>
<td></td>
</tr>
<tr>
<td>Liquor</td>
<td></td>
</tr>
</tbody>
</table>

Have you ever consulted a physician for your alcohol use?  ☐ Yes  ☐ No
Physician/facility, Dates, and Details

Have you ever been arrested for driving under the influence of alcohol or drugs?  ☐ Yes  ☐ No
Dates, and Details

Have you ever had a problem or received treatment for drug use?  ☐ Yes  ☐ No
Dates, and Details

Treatment Date(s) ___________________________  Date Last Used ___________________________

Are you attending recovery group meetings?  ☐ Yes  ☐ No
☐ Alcoholics Anonymous  ☐ Narcotics Anonymous  ☐ Other: ________________________________

TOBACCO AND NICOTINE USE

a) Have you ever used cigarettes

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Frequency</th>
<th>Date Last Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td></td>
</tr>
</tbody>
</table>

b) Have you ever used any other form of tobacco products

<table>
<thead>
<tr>
<th>Quantity</th>
<th>Frequency</th>
<th>Date Last Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
<td>☐ Yes</td>
<td></td>
</tr>
<tr>
<td>☐ Yes</td>
<td>Specify type(s):</td>
<td></td>
</tr>
<tr>
<td>☐ Pipe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Cigars</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Chew</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Snuff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Nicorette gum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Nicotine patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AVIATION AND HOBBIES

Type:  ☐ Private  ☐ Commercial

Total Hours Experience: ___________________________

Hours Flown Per Year:  ☐ IFR  ☐ VFR  ☐ Student

<table>
<thead>
<tr>
<th>Type:</th>
<th>Quantity</th>
<th>Frequency</th>
<th>Date Last Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ IFR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ VFR</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Student</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you participate in any hazardous activities?

<table>
<thead>
<tr>
<th>☐ Yes (Provide details below and applicable questionnaire)</th>
<th>☐ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Auto/Cycle Racing</td>
<td></td>
</tr>
<tr>
<td>☐ Bungee Jumping</td>
<td></td>
</tr>
<tr>
<td>☐ Hang Gliding</td>
<td></td>
</tr>
<tr>
<td>☐ Mountain Climbing</td>
<td></td>
</tr>
<tr>
<td>☐ Scuba Diving</td>
<td></td>
</tr>
<tr>
<td>☐ Sky Diving</td>
<td></td>
</tr>
<tr>
<td>☐ Ultralight Flying</td>
<td></td>
</tr>
<tr>
<td>☐ Other</td>
<td></td>
</tr>
</tbody>
</table>
LIFESTYLE – HEALTH CREDIT WORKSHEET

IMPORTANT: Answers can GREATLY IMPACT Underwriting

General Information:
Are you married? ☐ Yes ☐ No

Highest level of education: 

Diet:
Do you adhere to any specific diet? Briefly describe.

Exercise:
Do you exercise? ☐ Yes ☐ No

What do you do and how often?

Health:
Do you obtain routine medical, dental, and vision screening? ☐ Yes ☐ No

Please describe.

Social:
Are you currently employed? ☐ Yes ☐ No

What is your occupation?

If retired, briefly describe what you did before retirement.

What are some of your hobbies and interests?

Are you active in any clubs, church, volunteer groups, boards, charities? Please describe.

Travel:
Do you travel? ☐ Yes ☐ No


Do you have any motor vehicle infractions/accidents in the last 5 years? ☐ Yes ☐ No

Please describe.

Over-the-counter Supplements: (check all that apply) ☐ Baby Asprin daily ☐ Fish Oil ☐ Vitamins

Please list any other supplements.

Insured Name: ____________________________ Date of Birth: ____________
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
(This authorization complies with HIPAA Privacy Rules)
Provide a signed copy to the Proposed Insured

This authorization will permit Zenith Marketing Group, Inc. to obtain and release nonpublic personal information about me, the proposed insured named below, for the purpose of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions (“the companies”) listed below. Information that may be released to and disclosed by Zenith Marketing Group, Inc. and the companies listed below pursuant to this authorization shall include any and all information, to the extent permitted by applicable law.

Information to be released pursuant to this authorization includes any personal health information, records or data concerning my past, present or future mental, physical, or behavioral health or condition (“Information”), to the extent permitted by law. “Information” includes all information, records, or data relating to my: physical or mental history or condition, medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances, occupation, avocation, including any hazardous hobbies, driving records, aviation activities, and other personal traits.

I understand that this information may include results from blood, saliva, urine, and other tests. I further understand that this information may, if applicable, include information regarding diagnosis, prognosis, and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2), serious communicable disease or infection, including sexually transmitted diseases, HIV infection, including medical tests results.

I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, medical testing laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf (“My Providers”), consumer reporting agency, and any state Motor Vehicle Department to disclose the entire medical records and any other protected health information concerning me to release information about me to Zenith Marketing Group, Inc., the companies referenced below (“the companies”), their agents, affiliates, employees, and third party representatives. I also authorize the MIB to release information directly to any company, provided the insurer is a member of the MIB.

I understand that information disclosed to Zenith Marketing Group, Inc. may have been subject to state and federal privacy laws and regulations. Once information is disclosed to Zenith Marketing Group, Inc., it may no longer be subject to those laws and regulations. I understand that if I refuse to sign this Authorization to release my complete medical records, Zenith Marketing Group, Inc. may not be able to process my request.

A photocopy of this authorization shall be as valid as the original. This authorization shall remain in force for 24 months following the date of my signature below, unless revoked by me in writing and written notice of the revocation is provided to Zenith Marketing Group, Inc., 303 West Main Street, Suite 200, Freehold, NJ 07728. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. Any action taken prior to the notice of revocation shall be valid.

I acknowledge that I have received a copy of this authorization.

Signature of Proposed Insured or Authorized Representative

Date

If signed by Authorized Representative, describe authority (i.e. parent or guardian of a minor child, etc.) and relationship to Proposed Insured

Printed Name of Proposed Insured

Social Security #

Date of Birth

Address of Proposed Insured

Name of Agent

AI Credit
Allianz
Allianz of NY
Allstate of NY
American Equity
American General
American General of NY
American National
APPS
Assurant
AXA Equitable
Aviva
Banner Life
Chase Insurance
Clinical Reference Lab (CRL)

CMS II
Company of NY
Companion of NY
Coventry First
EMSI
ExamOne
Express Imaging Services
Fidelity and Guaranty Life
Fidelity Security
First MetLife Investors
Foresters
Genworth Life and Annuity
Genworth Life of NY
Guardian
ING/USA
John Hancock

Lafayette Life
Life of the Southwest
Lincoln Benefit Life
Lincoln Financial Group
MetLife
Minnesota Life
Mutual of Omaha
National Life Insurance Company
National Western Life
Nationwide Financial
New York Life
North American Life & Health
North American Life & Health of NY
Penn Mutual
Portamedic

Presidential
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life
Protective Life & Annuity of NY
Prucro Life Insurance Company
Prucro Life Insurance Co. of NJ
Prudential Insurance Co. of America
Reliastar
Reliastar of NY
SBLI of Mass.
Security Life of Denver
Security Mutual
Security Mutual of NY

Sentinel
Southland
Standard
Superior Mobile Medics
Transamerica
Union Central
United Home Life
United of Omaha
US Life of NY
West Coast Life
William Penn
Zenith Marketing Group

JBREV062012
INSTRUCTION TO AGENT:
THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE

NOTICE OF INFORMATION PRACTICES

In connections with your informal inquiry about 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 includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request of the insurance companies listed in this Notice, you will be informed whether or not an investigative consumer report was requested, and if so, 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 to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their reinsurers may, however, make a brief report thereon the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational 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 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 it may have in your life. 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112 Tel. (617) 426-3660.

The companies listed in this Notice or their reinsurers may also release information in their files to other life insurance companies to whom you apply for life or health insurance, or to whom a claim or benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on the information provided by you. The companies may also seek information from others, such as medical professionals who have treated you.

You have the right to be told about, and to see and copy, if you wish, items of personal information about you which appear in the insurance companies file, 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 LISTED INSURANCE COMPANIES AND YOUR AGENT’S INFORMATION PRACTICES IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR WRITTEN REQUEST TO ZENITH MARKETING GROUP, INC., 303 WEST MAIN STREET, SUITE 200, FREEHOLD, NJ 07728.
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
(This authorization complies with HIPAA Privacy Rules)

Provide a signed copy to the Proposed Insured

This authorization will permit Zenith Marketing Group, Inc. to obtain and release nonpublic personal information about me, the proposed insured named below, for the purpose of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions (“the companies”) listed below. Information that may be released to and disclosed by Zenith Marketing Group, Inc. and the companies listed below pursuant to this authorization shall include any and all information, to the extent permitted by applicable law.

Information to be released pursuant to this authorization includes any personal health information, records or data concerning my past, present or future mental, physical, or behavioral health or condition (“Information”), to the extent permitted by law. “Information” includes all information, records, or data relating to my: physical or mental history or condition, medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances, occupation, avocation, including any hazardous hobbies, driving records, aviation activities, and other personal traits.

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I authorize any physician, health care provider, health plan, medical professional, hospital, clinic, medical testing laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf (“My Providers”), consumer reporting agency, and any state Motor Vehicle Department to disclose the entire medical records and any other protected health information concerning me to release information about me to Zenith Marketing Group, Inc., the companies referenced below (“the companies”), their agents, affiliates, employees, and third party representatives. I also authorize the MIB to release information directly to any company, provided the insurer is a member of the MIB.

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Signature of Proposed Insured or Authorized Representative

Date

If signed by Authorized Representative, describe authority (i.e. parent or guardian of a minor child, etc.) and relationship to Proposed Insured

Printed Name of Proposed Insured

Social Security #

Date of Birth

Address of Proposed Insured

Name of Agent

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<tr>
<th>Name</th>
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ZENITH MARKETING GROUP INC.

Social Security Number: ___________