

# First Look

**Preliminary Inquiry for Insurance**



**800-733-0054**

Fax **732-577-0111**

**[www.zenithmarketing.com](http://www.zenithmarketing.com)**



303 West Main Street, Suite 200  
Freehold, NJ 07728



# PRELIMINARY INQUIRY

NOT AN APPLICATION FOR INSURANCE

## PERSONAL HISTORY

Name (First, MI, Last):

- Male  
 Female

Date of Birth (MM/DD/YYYY)

Current Age:

Soc. Sec. #

Driver's License # / State

Street Address

City

State

Zip

Occupation

Annual Earned Income

Duties

Net Worth

## 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: \_\_\_\_\_

Face amount desired

Premium amount desired

Rate class desired

What is the purpose of the insurance?

Name of beneficiary

Relationship

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

## PENDING AND IN FORCE COVERAGE None

Company	Issue or Application Date	Amount	Final Action/ Risk Classification	Annual Premium	Replacement Planned? <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**MEDICAL HISTORY**

Height: \_\_\_\_\_ feet \_\_\_\_\_ inches      Weight: \_\_\_\_\_ pounds

Name, Address, & Phone Number of Personal Physician

Date Last Consulted

Reason Last Consulted

Medication Prescribed

Advice & Treatment Given

**OTHER MEDICAL TESTS** - provide details for all that apply:

Test	Date(s)	Results <i>If abnormal, please provide details</i>
Blood Pressure		
Cholesterol		Total: _____mg Cholesterol/HDL Ratio _____
EKG		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
X-ray		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Colonoscopy		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Mammogram (women only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Prostate Exam (men only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Prostate Specific Antigen (PSA) (men only)		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

*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.*

Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**CHEST PAIN - CORONARY**  *Not Applicable*

Date of diagnosis or first onset of symptoms: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Heart Attack?  Yes, Date: \_\_\_\_\_  No

Surgery:	Any symptoms post-operatively?
<input type="checkbox"/> Angioplasty, Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bypass, Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Valve Replacement, Date: ____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Number of diseased vessels: \_\_\_\_\_

Date of last Stress EKG: \_\_\_\_/\_\_\_\_/\_\_\_\_

Results:  Normal  Abnormal: (provide details):

Date of last Echocardiogram \_\_\_\_/\_\_\_\_/\_\_\_\_

Results:  Normal  Abnormal: (provide details):

Arrhythmias?  Yes (provide details)  No

Heart enlargement?  Yes (provide details)  No

**DIABETES**  *Not Applicable*

Date of Diagnosis: \_\_\_\_\_ Age@ Diagnosis: \_\_\_\_\_

Treatment:  Diet Only  Oral Medication  Insulin

Dosage and Details:

Blood Glucose Levels: Checked @ Home?  Yes  No  
Results: \_\_\_\_\_  
Frequency: \_\_\_\_\_  
Last Glycohemoglobin level: \_\_\_\_\_ mg%  
(Hemoglobin A1c)  
Date: \_\_\_\_\_

Ever Had: Protein in urine?  Yes  No Microalbumin in urine?  Yes  No  
Eye Trouble?  Yes  No Kidney Trouble?  Yes  No  
Heart Trouble?  Yes  No Neuritis or neuralgia?  Yes  No  
High Blood Pressure?  Yes  No Insulin Reactions?  Yes  No

**CANCER**  *Not Applicable*

Name of Cancer (i.e. carcinoma, sarcoma, melanoma, etc.)

Location of Cancer

Date of Diagnosis

Date of Last Treatment

Type(s) of Treatment: (check all that apply & provide dates of treatment)

<input type="checkbox"/> Surgery _____	<input type="checkbox"/> Radiation _____
<input type="checkbox"/> Chemotherapy _____	<input type="checkbox"/> Hormone Therapy _____
<input type="checkbox"/> Immunotherapy _____	<input type="checkbox"/> Other: _____

Stage of Cancer

Grade of Cancer

<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Other: _____	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Other: _____
<input type="checkbox"/> A <input type="checkbox"/> A1 <input type="checkbox"/> A2	
<input type="checkbox"/> B <input type="checkbox"/> B1 <input type="checkbox"/> B2	
<input type="checkbox"/> C <input type="checkbox"/> C1 <input type="checkbox"/> C2	
<input type="checkbox"/> D <input type="checkbox"/> D1 <input type="checkbox"/> D2	

Metastasis?  Lymph Nodes: \_\_\_\_\_  Other Organs Tissues: \_\_\_\_\_

Recurrence?  Yes (provide details):

No

Current Medications:  
(include frequency and dosage)

**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)

	Age (if living)	Age at death	Onset age of disease	Details
Father				
Mother				
Brothers				
Sisters				

Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**DRUG AND ALCOHOL USE**  Not Applicable

Do you currently drink alcohol?  Yes  No  
Provide details below

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

Type:	Amount Per Week
Beer	
Wine	
Liquor	

Type:	Amount Per Week
Beer	
Wine	
Liquor	

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  
Types of Drugs Used

Treatment Date(s)

Date Last Used

Are you attending recovery group meetings?  Yes  No  
 Alcoholics Anonymous  Narcotics Anonymous  Other: \_\_\_\_\_

**TOBACCO AND NICOTINE USE**

**AVIATION AND HOBBIES**  Not Applicable

		Quantity	Frequency	Date Last Used
a) Have you ever used cigarettes?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
b) Have you ever used any other form of tobacco products?	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify type(s): <input type="checkbox"/> Pipe <input type="checkbox"/> Cigars <input type="checkbox"/> Chew <input type="checkbox"/> Snuff <input type="checkbox"/> Nicorette gum <input type="checkbox"/> Nicotine patch <input type="checkbox"/> Other: _____			

Type:  Private  Commercial

Total Hours Experience:

Hours Flown Per Year: Last Year :  This Year:

Check if Applicable

IFR  
 VFR  
 Student

Do you participate in any hazardous activities?  
 Yes (provide details below and applicable questionnaire)  No

Ultralight Flying  Bungee Jumping  Scuba Diving  Auto/Cycle Racing  
 Sky Diving  Hang Gliding  Mountain Climbing  Other: \_\_\_\_\_



Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**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 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	Banner Life	Foresters	Mutual of Omaha	Protective Life	Southland
Allianz	Chase Insurance	Genworth Life and Annuity	National Life Insurance Company	Protective Life & Annuity of NY	Standard
Allianz of NY	Clinical Reference Lab	Genworth Life of NY	Nationwide Financial	Pruco Life Insurance Company	Sun Life Financial
Allstate of NY	(CRL)	Guardian	New York Life	Pruco Life Insurance Co. of NJ	Transamerica
American Equity	CMS II	ING/USA	North American Life & Health	Prudential Insurance Co. of NJ	Union Central
American General	Companion of NY	John Hancock	North American Life & Health of NY	America	United Home Life
American General of NY	Coventry First	Lafayette Life	Old Mutual	Reliastar	United of Omaha
American National	EMSI	Life of the Southwest	Penn Mutual	Reliastar of NY	US Life of NY
APPS	ExamOne	Lincoln Benefit Life	Portamedic	SBLI of Mass.	William Penn
Assurity	Express Imaging Services	Lincoln Financial Group	Presidential	Security Life of Denver	Zenith Marketing Group
AXA Equitable	Fidelity Security	MetLife	Principal Life Insurance Company	Security Mutual	
Aviva	First MetLife Investors	Minnesota Life	Principal National Life Insurance Company	Security Mutual of NY	



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CLIENT'S COPY



Zenith Marketing Group Inc. (800) 733-0054 Fax: (732) 577-0111 www.zenithmarketing.com

Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

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 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.

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 understand that information disclosed to Zenith Marketing Group 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.

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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

Table listing various insurance agents and companies such as AI Credit, Allianz, Banner Life, Chase Insurance, Genworth Life and Annuity, National Life Insurance Company, Protective Life, Southland, etc.



Proposed Insured: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

**INSTRUCTIONS TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.****NOTICE TO PROPOSED INSURED**

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 to the life 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 member. 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 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 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 for 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 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.

AI Credit	Banner Life	Foresters	Mutual of Omaha	Protective Life	Southland
Allianz	Chase Insurance	Genworth Life and Annuity	National Life Insurance Company	Protective Life & Annuity of NY	Standard
Allianz of NY	Clinical Reference Lab	Genworth Life of NY	Nationwide Financial	Pruco Life Insurance Company	Sun Life Financial
Allstate of NY	(CRL)	Guardian	New York Life	Pruco Life Insurance Co. of NJ	Transamerica
American Equity	CMS II	ING/USA	North American Life & Health	Prudential Insurance Co. of	Union Central
American General	Companion of NY	John Hancock	North American Life & Health of NY	America	United Home Life
American General of NY	Coventry First	Lafayette Life	Old Mutual	Reliastar	United of Omaha
American National	EMS1	Life of the Southwest	Penn Mutual	Reliastar of NY	US Life of NY
APPS	ExamOne	Lincoln Benefit Life	Portamedic	SBLI of Mass.	William Penn
Assurity	Express Imaging Services	Lincoln Financial Group	Presidential	Security Life of Denver	Zenith Marketing Group
AXA Equitable	Fidelity Security	MetLife	Principal Life Insurance Company	Security Mutual	
Aviva	First MetLife Investors	Minnesota Life	Principal National Life Insurance Company	Security Mutual of NY	

