

Personal Information Page

Please complete this form in its entirety. Missing information may delay the establishment of your policy.

Personal Information

Name:	Sex: Male / Female
Date of Birth:	Social Security #
Birthplace:	Citizenship:
Home Address:	
Home Phone:	Work Phone:
Cell Phone:	Email:
Driver's License #	Driver's License State:
DL Issue Date:	DL Expiration Date:
Annual Earned Income:	Unearned Income Net Worth:
Liquid Assets (ESTIMATED):	
Occupation:	Name of Employer:
Employer Address:	

Personal History Questions

1. Do you anticipate any foreign travel within the next 2 years? Yes No
2. Within the last 3 years have you been, or within the next 2 years do you expect to become a pilot? Yes No
3. Within the last 3 years have you taken part in, or within the next 2 years expect to take part in any hazardous activities or extreme sports (diving, hang gliding, para sailing, skydiving...)? Yes No
4. Within the last 5 years, have you been in a motor vehicle accident or convicted of a moving violation? Yes No
5. Within the last 10 years, have you been convicted of operating a motor vehicle while under the influence of alcohol or drugs? Yes No
6. Have you ever been convicted of a felony, or currently on parole or probation? Yes No

If you answered yes to any of the questions above, please provide explanation below.

Account Information

Primary Beneficiary 1

Name: _____ Relationship: _____ Social Security # _____

Date of Birth: _____ Percent: _____

Primary Beneficiary 2

Name: _____ Relationship: _____ Social Security # _____

Date of Birth: _____ Percent: _____

Contingent Beneficiary 1

Name: _____ Relationship: _____ Social Security # _____

Date of Birth: _____ Percent: _____

Contingent Beneficiary 2

Name: _____ Relationship: _____ Social Security # _____

Date of Birth: _____ Percent: _____

In Force Life Insurance: IF NONE, LEAVE BLANK

Date Issued: _____ Carrier: _____ Type: _____

Insured: _____ Face Amount: _____ Policy # _____

Spouse: _____

Siblings (If Juvenile Insured): _____

**Additional Requirements for Disability Insurance:
IF NOT APPLYING FOR DIABILITY INSURANCE PLEASE LEAVE BLANK**

Employer Paid Benefits

Plan Design: _____

Benefit Amount: _____ Benefit Period: _____

Elimination Period: _____ Other Individual Coverage: _____

Number of Employees: _____ Owner: _____

MEDICAL INFORMATION

Please include the name, address, and telephone number of each physician listed.

<p style="text-align: center;">Personal Primary Care Physician:</p> <p>Name:</p> <p>Address:</p>	<p style="text-align: center;">Telephone Number:</p>	<p style="text-align: center;">Date of Last Visit:</p>	<p style="text-align: center;">Reason for Visit:</p>
<p style="text-align: center;">Specialist:</p> <p>Name:</p> <p>Address:</p>	<p style="text-align: center;">Telephone Number:</p>	<p style="text-align: center;">Date of Last Visit:</p>	<p style="text-align: center;">Reason for Visit:</p>
<p style="text-align: center;">Specialist:</p> <p>Name:</p> <p>Address:</p>	<p style="text-align: center;">Telephone Number:</p>	<p style="text-align: center;">Date of Last Visit:</p>	<p style="text-align: center;">Reason for Visit:</p>
<p style="text-align: center;">Specialist:</p> <p>Name:</p> <p>Address:</p>	<p style="text-align: center;">Telephone Number:</p>	<p style="text-align: center;">Date of Last Visit:</p>	<p style="text-align: center;">Reason for Visit:</p>
<p style="text-align: center;">List any Clinics or Hospitals</p> <p>Name:</p> <p>Address:</p>	<p style="text-align: center;">Telephone Number:</p>	<p style="text-align: center;">Date of Admission:</p>	<p style="text-align: center;">Reason for Admission:</p>

List all current medications: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	This form is HIPAA compliant
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Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, M. Williamson Insurance Services, brokers, contractors, employees, representatives and agents working through M. Williamson Insurance Services for purposes of the Proposed Insured applying for or evaluating insurance coverage. M. Williamson Insurance Services

Insurance Companies and Agencies			
Advantage Insurance Network, Inc. Allianz American General Life (AIG) American National Americo Assurity Life Accordia Life Ameritas AVS, LLC AUS Underwriting AXA / MONY / AXA Equitable Banner Life Beneficial Financial Group Bragg Associates Columbus Life Concord Capital/INSCAP Coventry First, LLC Equity Key, LLC Equity Release Examination Management Services, Inc. Fasano Associates, Inc.	Fidelity & Guaranty Life Ins. Co. First Global Financial & Insurance First Insurance Funding First Penn Foresters General American Life Ins. Co. Global Insurance Underwriters GE Financial Assurance Co. Genworth Life Insurance Co. Genworth Life and Annuity Guardian Life Ins. Co. Hartford Life Insurance Co. Industrial Alliance Pacific ISC Services John Hancock Life Ins. Co. John Hancock USA Lafayette Life Lewis and Ellis, Inc. Life Insurance of the Southwest LifeShare Lincoln Financial/ Lincoln Life Lincoln National Life Insurance Co. Massachusetts Mutual	Metropolitan Life MetLife Investors USA Insurance Co. Minnesota Life / Securian Mutual of Omaha M. Williamson Insurance Services National Life of Vermont National Western Nationwide Life & Annuity Co. New Investor World, Inc. New York Life Insurance Co. North American Co. Old Mutual Financial Network OneAmerica Pacific Life Penn Mutual Premium Funding Group (PFG) Pioneer Mutual Phoenix Life Presidential Life Principal Life Insurance Company Principal National Life Insurance Company Professional Underwriting Services Protective Life Ins Co. Prudential Life Ins. Co. / Pruco Life	RSA Medical SBLI Security Mutual Standard Life Sun Life Ins. Co. of America Sun Life Ins. Co. of Canada Superior Medical Group Symetra Transamerica Life Insurance Co. Travelers Life & Annuity 21st Services Union Central Life United of Omaha USG Annuity & Life Voya - ReliaStar Life of New York Voya - ReliaStar Voya - Security Connecticut Life Voya - Security Life of Denver West Coast Life Insurance Co. Western Reserve Life William Penn Life Ins. Co. Zurich American Life Insurance Company

Additional Insurers and Agencies:

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to **AIN Member Firm**, the Insurers and Agencies listed afore and to:

Agent/Producer Name: _____

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

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). If minor children are proposed for coverage, the above statements are made by the 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 _____ 20 _____
Signature of Proposed Insured / Guardian or Custodian / Authorized Representative
X _____ Printed Name: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice 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.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 866-692-6901.

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. This also authorizes 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 REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.