Preliminary Medical History and Risk Assessment

(Not an Application for Insurance)

TRITON BROKERAGE GROUP, INC.

Insured Information

Proposed Insured 1	**Date of Birth:**	
Name (First, Middle, Last)		
Height:	Weight:	☐ Gain ☐ Loss Pounds in past year?
Currently pregnant: ☐Yes ☐No If "Yes," anticipated delivery date:		
Current Tobacco Use: ☐Yes ☐No Type: _____ If quit, date last used: _____ Type: _____		

Proposed Insured 2	**Date of Birth:**	
Name (First, Middle, Last)		
Height:	Weight:	☐ Gain ☐ Loss Pounds in past year?
Currently pregnant: ☐Yes ☐No If "Yes," anticipated delivery date:		
Current Tobacco Use: ☐Yes ☐No Type: _____ If quit, date last used: _____ Type: _____		

Amount Applying For: _____

Policy Type: __ Term __ UL __Whole Life __ Survivorship __ DI

Amount Applying For: _____

Policy Type: __ Term __ UL __Whole Life __ Survivorship __ DI

Section 1

If more space needed for details listed in the following Sections, please attach additional sheet.

Has any person proposed for insurance ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: **(Circle conditions to which "Yes" answer applies and give details below)**		**Proposed Insured 1** Yes	No	**Proposed Insured 2** Yes	No
(a)	Any disorder or disease of the brain or nervous system (such as paralysis, epilepsy, stroke, convulsions, chronic headache).....	☐	☐	☐	☐
(b)	Any disorder or disease of the heart, blood vessels, or circulatory system (such as high blood pressure, heart attack, heart murmur, chest pain).....	☐	☐	☐	☐
(c)	Any disorder or disease of the respiratory system (such as Asthma, bronchitis, emphysema, tuberculosis).....	☐	☐	☐	☐
(d)	Any disorder or disease of the stomach, liver, intestines, rectum, pancreas, or abdominal organs.....	☐	☐	☐	☐
(e)	Any disorder or disease of the genitourinary organs (such as kidneys, urinary tract, blood or sugar in the urine, chronic inflammation).....	☐	☐	☐	☐
(f)	Any disorder or disease of the skeletal system (such as arthritis, osteoporosis, joints, bones, spine, muscles).....	☐	☐	☐	☐
(g)	Any disorder or disease of eyes, ears, nose or throat.....	☐	☐	☐	☐
(h)	Any disorder or disease of the blood, skin, thyroid, lymph or other glands (such as anemia, diabetes).....	☐	☐	☐	☐
(i)	Any psychiatric or mental health disorders or diseases (such as attempted suicide, Bipolar, Obsessive-compulsive).....	☐	☐	☐	☐
(j)	Any gynecological disorders or diseases (such as irregular Pap Smear, Toxic Shock Syndrome).....	☐	☐	☐	☐
(k)	Any cancer, tumor, cyst or nodule.....	☐	☐	☐	☐
(l)	Any sexually transmitted disorders or diseases.....	☐	☐	☐	☐
(m)	Any disorders or diseases of the immune system except those related to the Human Immunodeficiency Virus (AIDS Virus).....	☐	☐	☐	☐

Please provide details for any/all "Yes" responses.

	Question Number	**Date of Diagnosis**	**Diagnosis, Medication or Treatment Prescribed**	**Medical Professional or Facility**
Proposed Insured 1				
Proposed Insured 2				

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SSection 2

Has any person proposed for insurance ever been diagnosed or treated by a member of the medical profession for: **(Circle conditions to which "Yes" answer applies and give details below)**	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
(a) Immune deficiency, anemia, recurrent fever, fatigue or unexplained weight loss, malaise, loss of appetite, diarrhea, fever of unknown origin, severe night sweats; unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia.....	☐	☐	☐	☐
(b) Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS).....	☐	☐	☐	☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SSection 3

Has any person proposed for insurance ever: **(Circle conditions to which "Yes" answer applies and give details below)**	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
(a) Used narcotics, barbiturates, amphetamines, hallucinogens, marijuana, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician.....	☐	☐	☐	☐
(b) Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs.....	☐	☐	☐	☐
(c) Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous.....	☐	☐	☐	☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

SSection 4

The following questions in Section 4 do not include answers related to the Human Immunodeficiency Virus (AIDS virus) or for minor viruses, injuries, common colds that prevented normal activities for a period of less than five (5) days. Within the past five (5) years, has any person proposed for insurance **(Circle items or conditions to which "Yes" answer applies and give details below)**	Proposed Insured 1 Yes	Proposed Insured 1 No	Proposed Insured 2 Yes	Proposed Insured 2 No
(a) Been treated, examined or advised by a member of the medical profession for any condition other than stated above.....	☐	☐	☐	☐
(b) Been advised by a member of the medical profession to get specified medical care, hospitalization, surgery or diagnostic test, which has not been completed.....	☐	☐	☐	☐
(c) Been an inpatient or outpatient in a hospital, clinic, medical facility, or any similar entity.....	☐	☐	☐	☐
(d) Had any diagnostics test, electrocardiogram (EKG), MRI, CT-Scan or X-ray.....	☐	☐	☐	☐
(e) Been on, or advised to be on any prescribed, non-prescribed (over the counter) medication or prescribed diet.....	☐	☐	☐	☐
(f) Been unable to work, attend school or perform normal activities of life age and gender or been confined at home....	☐	☐	☐	☐
(g) Has made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition.....	☐	☐	☐	☐

Please provide details for any/all "Yes" responses.

	Question Number	Date of Diagnosis	Diagnosis, Medication or Treatment Prescribed	Medical Professional or Facility
Proposed Insured 1				
Proposed Insured 2				

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SSection 5

For the following Family Medical History question, please provide in section number 8 below for each parent or sibling: diagnosis, age of diagnosis, date last treated, age. If still alive and if not alive, age, date, and cause of death.	Proposed Insured 1 Yes No	Proposed Insured 2 Yes No
Has any person proposed for insurance had a parent or sibling diagnosed or treated by a member of the medical profession for certain conditions, such as heart or vascular disease, cancer, diabetes, high blood pressure, kidney disease, attempted suicide or mental illness.....	☐ ☐	☐ ☐

Please provide details for any/all "Yes" responses.

	Family Member	Age of Diagnosis	Diagnosis	Date Last Treated	Age (If Alive) If not alive, age of death and cause of death.
Proposed Insured 1					
Proposed Insured 2					

Name, Address and Phone Number of Personal Physician or Medical Facility that is consulted for routine health care or periodic check-ups.	
Proposed Insured 1	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
Proposed Insured 2	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:
	Name:
	Address:
	Phone Number:
	Date and Reason of last consult:

I have read or have had read to me the completed Supplemental Application before signing below. The above statements and answers are true and complete to the best of my knowledge and belief. I agree that such statements and answers shall be part of the application and shall be considered the basis of any insurance issued.

Proposed Insured 1 (Sign Name in Full)	Date	Proposed Insured 2 (Sign Name in Full)	Date
Signature of Parent or Guardian	Date	Signature of Witness	Date

Authorization To Obtain and Disclose Information

This Authorization complies with HIPAA, HITECH and GLBA Privacy Regulations

TRITON BROKERAGE GROUP, INC.

The terms that follow have the respective meanings when used in this authorization:
Authorization: To obtain and disclose information. Insurance Support Organization: Medical Information Bureau, Inc. and/or Consumer Reporting Agency. Bureau: Medical Information Bureau, Inc.

I understand that the life insurance companies named below, their reinsurers, and insurance support organizations, my independent insurance representatives, and those persons and employees authorized to represent them, including those persons defined as "business associates" under the HITECH Act, may need to collect information on me in regard to proposed coverage.

Accordia Life | AIG / American General | Allianz | Allianz Life of NY | American Equity | American National | Assurity | Athene Annuity & Life | AXA Equitable | Banner Life | Brighthouse Financial | Cincinnati Life | Companion of NY | Equitrust | Fidelity & Guaranty | Fidelity & Guaranty of NY | Fidelity Life | Foresters | Forethought Life Insurance Co. | Genworth Life | Genworth Life and Annuity Ins. Co. | Genworth LTC | Guarantee Trust Life | Guggenheim | Great American | Illinois Mutual | Security Life of Denver | Integrity Life | John Hancock LTC | John Hancock of NY | John Hancock USA (Man) | Legal & General America | Life Insurance Co. of the Southwest | Lincoln Life of NY | Lincoln National Life | Lincoln National Life of NY | Minnesota Life | Mutual of Omaha | National Life Group | Nationwide | New York Life | North American | Peterson International | Principal Life Ins. Co. | Principal National Insurance Co. | Protective Life | Protective Life of NY | Prudential Ins. Co. of America | Pruco Life Insurance Co. | Reliance Standard | Saving Bank Life Insurance Co. of MA | Security Mutual Life | Symetra | Transamerica Insurance Company | Transamerica of NY | United of Omaha | Voya | William Penn of NY | Zurich

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers"), and any insurer, reinsurer, insurance support organization, financial source, and employer to disclose the types of information listed below when this authorization is presented. I authorize all said sources listed above, except the Bureau, to give such records or knowledge to Triton Brokerage Group, Inc. (TBG). I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.

This information includes my entire medical record and any other **Protected Health Information** concerning me. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness, and the use of alcohol, drugs, and tobacco. This also includes information on other insurance coverage, hazardous activities, character, general reputation, mode of living, finances, vocation, and other personal traits. This also includes genetic information about me or my family members.

By signing below, I terminate 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 file <u>without</u> restriction.

My **Protected Health Information** is to be disclosed under this authorization so that the insurance companies named above and their reinsurers may: 1) determine my insurability and underwrite my application for coverage by making eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance companies named above.

Authorization To Obtain and Disclose Information

This Authorization complies with HIPAA, HITECH and GLBA Privacy Regulations

TRITON BROKERAGE GROUP, INC.

The parties named below 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) the Bureau; or 4) other persons who perform business, professional, or insurance services for them.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I acknowledge receipt of this notice and understand that I have the right to revoke this authorization in writing, at any time, by sending written request to the address listed below. I understand that a revocation is not effective if any of My Providers have relied on this authorization or to the extent that any of the insurance companies named above have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

COMPLETED BY INSURED / PATIENT and ADVISOR

Signed At: _____ Date: _____ 20_____

Insured's Name: _____

DOB: _____ Social Security #:_____ DL #_____

Insured's Address: _____

_____

Insured's Signature _____ **Date:** _____

Advisor's Signature:_____ Print Name: _____

COMPLETED BY AUTHORIZED PROCESSING OFFICE PERSONNEL
Records to be Released to:

Authorized Processing Office Address:_____

_____

Phone: _____ Fax: _____ Email:_____

Print copy of this page for each additional proposed Insured