

# Senior Focus Group

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## Application & Procedures

1. Complete the enclosed HIPPA Authorization (Page 2) and sign at bottom.
2. Complete the Notification of Information Practices form (Page 3) and print and sign your name.
3. Print and sign your name on the Authorization form (Page 4).  
***It is not necessary to notarize your signature at this time until you are pre-qualified.***
4. Complete all information on pages 5, 6 and 7 and use additional paper if needed.
5. Print and sign your name on page 8
6. Mail the original Application to:

Shop Right Processing Center  
2121 Bodega Way  
Edmond, OK 73003

\* **Please Note:** The enclosed forms and questionnaires are necessary to evaluate your health status to qualify for the Senior Focus Group program. No health information or advice will be given to any applicant as this is for insurance qualification purposes only.

**AUTHORIZATION**

This Authorization is HIPPA compliant.

**X Proposed Insured:** \_\_\_\_\_

**X Date of Birth:** \_\_\_\_\_ **X Social Security #:** \_\_\_\_\_

Purpose:  
The purpose of this Authorization is to permit BIS to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes 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 BIS and the Companies listed below pursuant to this Authorization shall include any and all to the extent permitted by applicable law.

Information to be Released:  
The 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.

Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medication 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 test results.

Authorization:  
I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such Information to BIS, and its authorized representatives.

I specifically authorize the Companies listed on the next page to receive Information from and to release Information to BIS. I also specifically authorize BIS and the Companies listed on the next page to release Information about me to their reinsurers, underwriters or other persons or organizations performing business professional or insurance functions for them. I also authorize the MIB to release Information directly to any Company listed on the next page at the insurer's request, provided the insurer is a member of MIB.

I understand that the Information disclosed to BIS may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to BIS, it may no longer be subject to those laws and regulations.

I also authorize my Agent, named below, to receive Information and I authorize BIS to disclose such Information to my Agent as necessary to assist in the purpose of this Authorization to the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original. I will receive a copy of this authorization.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to BIS. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
**Proposed Insured's Signature (or that of Authorized Representative)**      **Date**

**X** \_\_\_\_\_  
**Print Name of Proposed Insured**

**If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.**

\_\_\_\_\_  
**Print Name of Agent**

\*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with Information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person whom coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask it to correct the information as provided in the Fair Credit Reporting Act.

## Notice of Information Practices

### Investigative Consumer Report

In addition to requesting a report from MIB, as a part of our underwriting process we or one of the insurance companies listed below may request an investigative consumer information report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with your or your family, friends, associates, or others with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is normally conducted, but you are entitled to make a specific request.

We keep such information reports confidential and use them only to evaluate and underwrite your application.

You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

### Disclosure on Information

We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer database secure to safeguard the information we have.

We may disclose personal information about you without prior authorization under certain circumstances. For example, we may disclose information about you to persons or organizations to allow such persons or organizations to perform a business, professional or insurance function for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. We may give information to accounting firms performing audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which you have applied for coverage or benefits. Information may be furnished your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law.

We may also disclose information to medical professional where required by law for the purpose of informing you of a medical problem of which you may not be aware of to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured lives.

No medical record information or personal information relating to your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

### You Can View and Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us what we know about you is incorrect we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we include your statement when we give your information to anyone outside BIS.

<b>X</b>	<b>X</b>	<b>X</b>
<b>Proposed Insured Initials</b>	<b>Date</b>	<b>Soc. Sec. #</b>

<b>X</b>	<b>X</b>
<b>Print Name</b>	<b>Signature</b>

Acacia Mutual American General Life American General Life of NY AIG Life AIG Life of NY Allianz Life Insurance Company American Mayflower American National Insurance Company American Life Insurance Company of NY Assurity Life Bankers Life of NY BISYS Insurance Services Business Mens Assurance Co of America Canada Life Assurance Canada Life of NY CAN Companion Life of NY Continental Assurance Company Empire General Life EMSI	Equitable Life of Iowa Fidelity Security F&G First Colony First Penn-Pacific First UNUM GE Capital Assurance GE Capital Assurance of NY GE Financial Assurance GE Life & Annuity/LOV General American Life Insurance Co. Gerber Life Insurance Company Guarantee Trust Life Hartford Life Insurance Illinois Mutual Indianapolis Life Insurance Company Jefferson Pilot Life Insurance John Hancock Life Insurance Company Keyport Life Insurance Company Lincoln Benefit Life Lincoln Life	Lincoln Life of NY Lloyd's of London Massachusetts Mutual Life Manulife USA Manulife USA of NY Metropolitan Life Insurance Compa MONY Mutual of Omaha Nationwide New York Life North American Life and Health North American Life and Health Old Line Life Old Republic Life Phoenix Physicians Mutual Life Protective Life Presidential Life Insurance Company Principal Life Insurance Company Provident Life and Accident Provident Mutual Prudential Insurance	ReliaStar Life Insurance ReliaStar Life Insurance of NY Security Connecticut Security Life of Denver Security Mutual Life Security Mutual Life of NY Southland Life Standard State Life Sun Life Financial Travelers Insurance UNUM Insurance United of Omaha Unum Provident Corporation UNUM Insurance United of Omaha Unum Provident Corporation US Financial US Life Insurance Co in the City of NY Valley Forge Life West Coast Life William Penn Zurich Life Zurich Life Insurance Company of NY
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I specifically authorize and request any insurance company and each Authorized Discloser to rely upon a photo static or facsimile or other reproduction of this Authorization.

Subject to my right to revoke this Authorization described above, it shall remain valid until, and shall expire on, the date one year following the date of my death.

**Authorized Disclosures:**

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I have signed this document and caused it to be acknowledged by a Notary on \_\_\_\_\_ 2006,

At \_\_\_\_\_  
(Date and Place)

X \_\_\_\_\_  
Print Name

X \_\_\_\_\_  
Signature

**\*Print Name and Sign.**

It is not necessary to notarize until you are pre-qualified

**PERSONAL HISTORY**

Name \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Monthly Earned Income \_\_\_\_\_ Occupation \_\_\_\_\_

Have you ever been party to a bankruptcy? \_\_\_\_\_ Are you a US Resident? (circle one) Yes No

Marital Status \_\_\_ Married \_\_\_ Separated \_\_\_ Unmarried (including single, divorced or widowed)

Daytime Phone (\_\_\_\_) \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_ Cellular (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

**TOBACCO / NICOTINE USAGE**

Have you ever smoked cigarettes? \_\_\_\_\_ If yes, date \_\_\_\_\_

Have you used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine, gum or patch)

\_\_\_\_\_

**MEDICAL HISTORY**

Your primary care physician: Doctor's name \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Date \_\_\_\_\_ Illness \_\_\_\_\_

\_\_\_\_\_

**What other Physicians have you consulted in the last 5 years and Why?** (Use additional paper if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**In what hospitals, clinics, or other health facilities have you ever been treated?** (Use additional paper if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please list all current medications** (Use additional paper if necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>FAMILY HISTORY</b> Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? If yes, please provide the following details: (Use additional paper if necessary)		
Relation (mother, father, brother, sister)	Diagnosis / Approximate age of disease of onset	Age at death

<b>DRUG AND ALCOHOL USAGE</b> (Use additional paper if necessary)		
Do you currently drink alcohol? Y / N Date of last consumption _____	Did you ever drink substantially more than present? Y / N	
Amount per week:	Amount per week:	
Beer	Beer	
Wine	Wine	
Liquor	Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use?	Y / N	
Have you ever been arrested for driving under the influence of alcohol? If yes, provide dates: _____	Y / N	
Have you ever used illegal drugs or sought treatment because of drug use? If yes, provide details: Types of drug(s) used: _____  Date of last use: _____	Y / N	
Doctor / Facility name and address: _____		

<b>CORONARY</b> _____ check here if this section is not applicable (Use additional paper if necessary)		
Date of diagnosis or first chest pain		
Number of diseased vessels:		
Dates / Details of treatment / surgery (examples: Angioplasty, Bypass)		
Date of last stress EKG		
Results of EKG		
By whom		
Any pain since treatment/surgery?		

<b>HAZARDOUS ACTIVITIES</b> _____ <b>check here if this section is not applicable</b> (Use additional paper if necessary)		
Are you a private pilot	(circle one)    Y    /    N	
How many total hours have you flown as a Pilot in Command?		
How many hours do you fly per year?		
Do you have an IFR (instrument flight rating)	(circle one)    Y    /    N	
Do you participate in the following activities? (circle those that apply)	Scuba Driving Bungee Jumping Ultra light Flying Auto/Motorcycle Racing	Mountain Climbing Hang Gliding Sky Diving

<b>CANCER</b> _____ <b>check here if this section is not applicable</b> (Use additional paper if necessary)		
Exact name and location of cancer		
Stage and grade		
Who would have the pathology report?		
Dates/details of treatment/surgery?	<hr/> <hr/>	

<b>DIABETES</b> _____ <b>check here if this section is not applicable</b> (Use additional paper if necessary)		
Date of diagnosis		
Treatment	(circle one)    Diet Only    Oral Medication    Insulin	
Do you regularly test your blood glucose?	(circle one)    Y    /    N	
Results	Frequency	
Latest result of glycohemoglobin	A1C test _____ mg% Date	
Have you ever had:	Y    /    N	
Eye trouble	Y    /    N	
Heart trouble	Y    /    N	
High blood pressure	Y    /    N	
Kidney trouble	Y    /    N	
Neuritis / neuralgia	Y    /    N	
Insulin reactions	Y    /    N	

I hereby certify the above information to be true and correct to the best of my knowledge.

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*X Name of Applicant*

*X Signature of Applicant*

*X Date*