Great Plains Annuity Marketing
11900 W. 87th Street Parkway, Suite 250
Lenexa, Kansas 66215-4517
www.greatplainsannuity.com **800-710-1115** **rich@gpam.biz**

Preliminary Underwriting Questionnaire and Authorization

Information and Instructions

Thank you for taking the time to complete the following pages. It is our goal to get the best possible offer for your client. In order to do that we need to have the most current health and lifestyle information regarding the proposed insured. After all pages have been completed and signed, please fax them to:

Attention: Life Quotes

Fax Number: (913) 492-9994

Please allow 48 hours for someone to contact you regarding this case.

Submitting Agent Information

Name_____ Telephone_____
Ext_____
Address_____ Unit_____
City_____ State_____ Zip_____
Fax_____ E-mail_____
Are you shopping this case? YES NO
If YES, what companies have you submitted or are you going to submit this case to?_____
_____
Based on your client's history what offer are you expecting?_____
What is the best way to contact you?_____

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Preliminary Underwriting Questionnaire

Please take a few moments to complete all sections of this questionnaire.
We will be better able to help if we have the most current and accurate information possible.

Section 1...Proposed Insured Information

Full Name_____ Age_____ Date of Birth_____/_____/_____

Sex_____ Height_____ Weight_____ Place of Birth_____ Marital Stauts_____

SSN/Tax ID Number_____ Employer & Occupation_____

Home Address_____ Unit/Apt_____

City_____ State_____ Zip Code_____

Driver's License Number_____ License State_____

US Citizen_____ If No, Date of Entry_____ Type of Visa_____

Section 2...Current and Desired Coverage Information

Amount of Coverage Requested_____ Type of Coverage Term UL WL

Owner_____ Relationship to Insured_____

Beneficiary_____ Relationship to Insured_____

Annual Income_____ Net Worth_____

Please List All Current Coverage

Company_____ Face Amount_____ Issue Year_____ Cash Value_____
Will This Policy Be Replaced_____

Company_____ Face Amount_____ Issue Year_____ Cash Value_____
Will This Policy Be Replaced_____

Company_____ Face Amount_____ Issue Year_____ Cash Value_____
Will This Policy Be Replaced_____

Has the Proposed Insured ever been denied, rated or had to postpone any life insurance coverage?_____

If yes, please complete the information below

Company_____ Rated / Declined / Postponed Year_____
Reason_____

Company_____ Rated / Declined / Postponed Year_____
Reason_____

Company_____ Rated / Declined / Postponed Year_____
Reason_____

Section 3...Medical History

Please circle Yes or No for all questions.

If yes answer applies to any questions, provide details, such as: date of first diagnosis, name and address of doctor, test performed, test results. medication(s) orrecommended treatment in the area provided.

1. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:
   - A. Heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? **YES NO**
   - B. A blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? **YES NO**
   - C. Cancer, tumors, masses, cysts or other such abnomalities? **YES NO**
   - D. Diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system? **YES NO**
   - E. Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestines? **YES NO**
   - F. A disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? **YES NO**
   - G. Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder? **YES NO**
   - H. Seizures, a disorder of the brain or spinal cord, or other nervous system abnormality including a mental or nervous disorder? **YES NO**
   - I. Arthritis, muscle disorder, connective tissue disease or other bone or joint disorders? **YES NO**

2. Has the Proposed Insured in the past three years had but not sought treatment for:
   - A. Fainting spells, nervous disorder, headaches, convulsions or paralysis **YES NO**
   - B. Any pain or discomfort in the chest or shortness of breath? **YES NO**
   - C. Disorders of the stomach, intestines, or rectum or blood in the urine? **YES NO**

3. What is the Proposed Insured's height_____ Weight_____

4. Is the Proposed Insured currently under treatment, therapy, or medical observation? **YES NO**
   If YES, Please explain_____
   _____
   _____

5. Please list all medications and dosages_____
   _____
   _____
   _____
   _____

Please explain any questions answered YES above_____
_____
_____
_____
_____

Section 4...Lifestyle Information

1. Has the Proposed Insured used tobacco of any form in the past 24 months? **YES NO**
   If YES, please list date of last nicotine use_____ Type of Tobacco_____
   Are you currently using nicotine gum or patch? **YES NO**

2. Has the Propsed Insured ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? **YES NO**

3. Has the Proposed Insured ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? **YES NO**

   If YES is answered to questions 2 or 3, please complete a Drug/Alcohol Questionnaire

4. Does the Proposed Insured engage in regular physical exercise other than which occurs during their work? **YES NO**
   Type of exercise Number of times each week For how many minutes
   _____
   _____

5. Is there a history of diabetes, stroke, heart disease, high blood pressure or kidney disease among the Proposed Insured's parents or siblings? **YES NO**

	Age, if living	Health	Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Brother/Sister				

6. In the past three years, has the Proposed Insured been in a motor vehicle accident, been charged with a moving violation, or had their license restricted or revoked? **YES NO**
   If YES, please explain_____
   _____

7. Does the Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? **YES NO**
   If YES, please list country, date, length of stay and purpose_____
   _____

Section 5...Physician Contact Information

Applicant's Personal Physician_____ Telephone_____
Name of Clinic_____
Address_____ Suite_____
City_____ State_____ Zip_____
Date of Last Visit_____
Reason for visit?_____
_____
Please list any other physicians, clinics, hospitals, or sanitariums the Proposed Insured has consulted with or been a patient of within the last five years on a seperate piece of paper.

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HIPAA AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Applicant's Name:_____

Address:_____

_____

City:_____ State:_____ Zip:_____

Telephone:_____

Date of Birth:_____

SSN:_____-_____-_____

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ or two years from date of signature.
(Date)

EVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the Requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

PURPOSE: To obtain life insurance.

_____ _____
Signature of Proposed Insured or Representative Date

_____
Print Name of Proposed Insured or Representative

_____ or _____
Relationship to Insured Legal Authority
Attach supporting documentation

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Authorization to Obtain Information Waiver and Acknowledgment Form

AUTHORIZATION:

I AUTHORIZE_____, OR any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (My Providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Great Plains Annuity Marketing (GPAM) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

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 record without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so the GPAM may: 1) underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below.

Allianz	John Hancock Life	Prudential
AIG-American General Life	Lafayette Life	Security Life of Denver
American National	Life of the Southwest	Standard Life and Accident
AmerUs Life	Lincoln Benefit	State Life
Assurity	Lincoln National	SunLife
Aviva	MetLife-General American	Transamerica Occidental
AXA/Equitable	MTL Insurance	Travelers Life
Banner Life	Mutual of Omaha-United of Omaha	West Coast Life
Chase	National Western Life	
Columbus Life	Nationwide	
Fidelity and Guaranty	North American	
First Penn Pacific	Pan-American Life	
General American	Presidential Life	
Indianapolis Life	Principal Life	
ING Security Connecticut	Protective Life	

Other Insurance Company:_____

This authorization shall remain in force for 24 months, beginning_____. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above named facility or GPAM, 11900 W. 87th Street Parkway, Suite 250, Lenexa, KS 66215. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

WAIVER AND ACKNOWLEDGMENT

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (th "Applicant") in favor of Great Plains Annuity Marketing (GPAM), its successors, assigns, shareholders, directors and employees (collectively "GPAM").

Applicant acknowledges, understands and agrees as follows:

* that Applicant has filed an application with GPAM intending to secure life insurance from one or more insurance underwriters.
* that, in the course of applying for life insurance coverage, GPAM has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
* that GPAM will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representative.
* that GPAM maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under Insurance policies issued and serviced by those Underwriters.
* that GPAM will use the Interchange to store some or all of the confidential and personal information Applicant has provided to GPAM, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
* that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
* that, even though GPAM has in place security measures GPAM believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though GPAM will continue to upgrade those security measures from time to time as circumstances warrant, GPAM can make no guarantee as to GPAM's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
* that GPAM cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
* that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in GPAM's possession and/or stored on the Interchange.
* that Applicant will indemnify GPAM for all costs and expenses incurred by GPAM or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I have received a copy of this document.
I AGREE this form shall be valid for twenty-four (24) months from the date shown below.

Signed on this date: _____/_____/_____

City:_____ State:_____

X_____ X_____

Signature of Proposed Insured/Parent or Guardian Signature of Witness

_____

Printed name of Proposed Insured/Parent or Guardian

HIPAA Privacy Rule compliant