

EXPERIENCE.
EXPERTISE.
SOLUTIONS.

2200 ROSS AVENUE
SUITE 4301
DALLAS, TEXAS 75201
PH 214.358.0011
877.842.1212
FAX 214.210.5998
www.EMERCURY.com



MEDICAL QUESTIONNAIRE

Client Name: _____ Date of Birth: _____ Male Female
Current Address: _____ US Citizen: Yes No
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Social Security Number: _____ Drivers Lic Number: _____ State of Issue: _____
Proposed Amount of Ins: _____ Plan: UL SUL VUL SVUL
Tobacco use: No Yes - type and date last used: _____ Height: _____ Weight: _____

MEDICAL HISTORY

Who is your personal physician? (Provide Doctor's name, address, and phone number) When were you last consulted and why?

What other physician have you consulted during the last five years? (Do not include insurance examinations)
List reason for consultations.

In the last 10 years, in what clinics, hospitals, or sanitariums have you been treated? List reason for treatment.

A signed Authorization to Obtain Information MUST accompany this request.

Financial Advisor: _____ Phone: _____

Email: _____ Date: _____

Approval for Mercury Financial Group to contact client.



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AUTHORIZATION TO OBTAIN INFORMATION

This authorization complies with the HIPAA Privacy Rule

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer or other organization, institution or person having information available as to a diagnosis treatment and prognosis with respect to any physical or mental condition, including alcohol or drugs and/or treatment of me, or my minor children (if proposed insured), any related information of me, or my minor children (if proposed insured) to provide all such information to the following insurance companies, their subsidiaries, reinsurer(s) or legal representatives:

Allianz Life Insurance Company, American General Life Insurance Company, American National, Aviva Life & Annuity, AXA Equitable, Banner Life, First Colony, Genworth Financial, John Hancock Company, General American Life Insurance Company, Lincoln National Insurance Company, Lincoln Benefit, MetLife, Nationwide Insurance Company, Pacific Life Insurance Company, Phoenix Insurance Company, Principal Financial, Protective Life Corporation, Prudential Financial, Reliastar Life (ING), Security Life of Denver (ING), Sun Life Financial, Transamerica Occidental Life Insurance, West Coast Life or Mercury Financial Group.

I understand that the information obtained by use of this Authorization will be used by said companies to determine eligibility for insurance, eligibility for benefits under an existing policy and for other business purposes in connection with the insurance relationship. Any information obtained will not be released by said companies to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, other business purposes, or as may be otherwise lawfully required or as I may further authorize. I agree the Authorization shall be valid for two years from the date shown below. I know that I may request to receive a copy of this Authorization. I reserve the right to revoke this authorization at any time prior to its expiration date by notifying Mercury Financial Group at the address above, but I acknowledge that my revocation will not have an effect on actions taken by Mercury Financial Group before my revocation. I acknowledge that my eligibility for enrollment in a health plan or for benefits or for coverage under an insurance policy for life or disability coverage may be conditioned on provision of this authorization. I agree that a photographic copy of this Authorization shall be as valid as the original.

Signed this _____ day of _____ 20 ____ .

X

Proposed Insured's Signature (Parent or Legal Guardian, if minor child)

Daytime Telephone:

Printed Name: _____
(First Name) (Middle Name) (Last Name) (Jr., III, etc)

Street Address: _____

City, State, Zip: _____

Print Financial Advisor's Name

Financial Advisor's Signature





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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

For: _____
Client Name Date of Birth SSN

I hereby give my consent and authorize the medical facility indicated below:

Physician: _____

Address: _____

To release medical records to:

RSA Medical
Medical Records Department
1255 Bond Street Suite 121
Naperville, IL 60563

Information to be Released: All Records
Dates of Service: Any and All
Purpose of Release: Chart Review

The purpose of release of the information is so that a chart review can be conducted to determine insurance eligibility, support for a claim, medical necessity, or for the purpose of quality assurance.

I understand that I may revoke this consent in writing at any time, although not retroactively, and that upon fulfillment of the above requested medical information or the lapse of one (1) year from the date of signature, whichever comes first, this consent will automatically expire without my express revocation. A photocopy of this authorization shall be as valid as the original.

I understand that the medical facility listed above may not condition treatment, payment, enrollment or eligibility on my signing this authorization. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in 45 C.F.R. 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. **The patient's medical record is privileged information which is protected by various State and Federal laws. Such information may not be further disclosed to other persons or entities without a separate written authorization from the patient.**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. The information authorized for release may include records which indicate the presence of a communicable or noncommunicable disease.

Patient must sign unless he/she is a minor or is unable to sign. If signature is not of patient, indicate legal relationship to patient.

Signed: _____ Date: _____

Relationship if not signed by patient: _____

