

EXPERIENCE.  
EXPERTISE.  
SOLUTIONS.

1445 ROSS AVENUE  
SUITE 4600  
DALLAS, TX 75202  
PH 214.358.0011  
PH 877.842.1212  
FAX 214.210.5998  
WWW.EMERCURY.COM



### MEDICAL QUESTIONNAIRE

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female  
Current Address \_\_\_\_\_ U.S. Citizen  Yes  No  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_ State of Issue \_\_\_\_\_  
Proposed Amount of Insurance \_\_\_\_\_ Plan  UL  SUL  VUL  SVUL LTC Rider  Yes  No  
Tobacco Use  No  Yes - Type and Date Last Used: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

### MEDICAL HISTORY

Please list ALL doctors seen in the last five (5) years. Also, please list ANY doctor seen in the last ten (10) years for medical treatment related to cancer or cardiac (heart/esophageal) issues.

Date last seen \_\_\_\_\_ Physician Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ For what condition did you visit this physician? \_\_\_\_\_

Date last seen \_\_\_\_\_ Physician Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ For what condition did you visit this physician? \_\_\_\_\_

Date last seen \_\_\_\_\_ Physician Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ For what condition did you visit this physician? \_\_\_\_\_

Date last seen \_\_\_\_\_ Physician Name \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_ For what condition did you visit this physician? \_\_\_\_\_

Financial Advisor \_\_\_\_\_ Phone \_\_\_\_\_  
Email \_\_\_\_\_ Date \_\_\_\_\_  
 Approved for Mercury Financial Group to contact client.

**A signed Authorization to Obtain Information MUST accompany this request.**



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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, my prescription records and history of medication prescribed, or my minor children (if proposed insured), to provide all such information to the following insurance companies, their subsidiaries, reinsurer(s) or legal representatives including but not limited to RSA Medical:

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 Life Insurance Company, Principal National Life Insurance Company, Protective Life Corporation, Prudential Financial, Reliastar Life (ING), Security Life of Denver (ING), Sun Life Financial, Transamerica Life Insurance Company, 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 that 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 a minor child)

Daytime Telephone

Printed Name

(First Name)

(Middle Name)

(Last Name)

(Jr., III, etc.)

Street Address

City, State, Zip



**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:

Mercury Financial Group	RSA Medical
1445 Ross Avenue	Medical Records Department
Suite 4600	1255 Bond Street, Suite 121
Dallas, TX 75202	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 and my prescription records and history of medication prescribed. The information authorized for release may include records which indicate the presence of a communicable or non-communicable 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: \_\_\_\_\_

