Informal Inquiry & HIPAA

Windsor Insurance
21820 Burbank Blvd. Suite 100 South
Woodland Hills, CA 91367
Phone: 800.410.9890
Fax: 818.594.5063
newbusiness@windsorinsurance.com

Current as of 1.2026

Informal Inquiry

Date: _____

CLIENT: PERSONAL INFORMATION

Name_____ Sex: Male____Female ____

Marital Status: Single ____ Married ____ Divorced ____ Domestic Partner ____

Date of Birth _____

SSN# (last four only) _____ U.S. Citizen: Yes ____ No____

Address _____

City _____ State _____ Zip _____

Office Phone_____ Mobile Phone _____

Email _____

DL # _____ State _____ Height _____ Weight _____

Occupation _____

CLIENT: PERSONAL FINANCIAL INFORMATION

Income Earned: _____ Income Unearned: _____ Net Worth: _____

AGENT/ADVISOR INFORMATION

Agent/Advisor Name _____

Firm Name _____

Office Phone_____ Mobile _____

Email _____

Broker Dealer (if applicable) _____

Life Insurance Questionnaire

Type of insurance you are requesting?

Universal Life ___ Whole Life ___ Variable ___ Survivorship___(UL___VUL___)

Term: Guaranteed Level premium: 10 ___ 15 ___ 20 ___ 30 ___

Face amount desired_____Primary reason for insurance _____

Do you have any other in-force life insurance in place? Yes____ No ___

Total amount in-force_____ Date of last application _____

Are you replacing any insurance? Yes ___ No ___ Face amount replaced _____

Carrier(s) being replaced _____

Do you currently use:

Cigarettes: Yes ___ No ___ If no, and less than 3 years, date last smoked _____

Cigars: Yes ___ No ___ If yes, frequency/quantity_____

Other: Yes ___ No ___ If yes, provide details_____

Have you used THC/CBD in any form within the last 5 yrs? If yes, provide method, frequency, date of last use

_____

Do you have plans to travel or reside outside the US? Yes ___ No ___ If yes, provide dates/details

_____

Have you piloted/flown an aircraft in the past two years? Yes ___ No ___ If yes, hours flown:

in total: _____ in past 12 months _____ expected to fly next year _____

Type of License _____ IFR: Yes ___ No ___

In the past 5 years have you: been in a motor vehicle accident, been charged with a moving violation, DUI or had your license revoked? Yes ___ No ___ If yes, provide dates and details

Have you ever engaged or plan on engaging in: mountain climbing, racing (auto/boat), underwater diving or any hazardous sport or hobby? Yes ___ No ___ If yes, provide dates and details

MEDICAL HISTORY

Primary Physician _____

Address _____ Phone _____

Date of last visit _____ Reason for visit _____

List all other medical specialists that you have seen in the last 5 years.
Include: Name & Specialty / Address / Phone / Date of visit / Reason for visit

_____

_____

_____

_____

_____

List all current medications _____

Have you ever been diagnosed with or treated for any of the following? If yes, provide the number and details.

1. Heart Attack
2. Heart Surgery
3. Heart Disease
4. Chest pain-cardiovascular disease
5. High blood pressure
6. Heart murmur
7. Stroke/TIA
8. Cancer
9. Diabetes (not during pregnancy)
10. Lupus
11. Ulcerative colitis/Crohn's
12. Lung/breathing disorder
13. Kidney disorder
14. Hepatitis/liver disorder
15. Nervous system disorder
16. Brain/spinal cord disorder
17. Depression
18. Alzheimer's or dementia

Other _____

Number	Details
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do your mother, father or sibling(s) have a history of cancer and/or heart disease? If yes, please indicate type of history, date of onset, current age or age at death if deceased.

_____

Authorization to Obtain and Disclose Confidential Information

This form is HIPAA compliant.

Proposed Insured's Name

Date of Birth

Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Windsor Insurance Associates, Inc. (WIA), NFP Insurance Services, Inc. (NFPISI), contractors, employees, representatives and agents working for or through WIA or NFPISI, including joint work provided by _____for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Insurers and Agencies

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records to be released may include, but are not limited to, information about my: (1) behavioral and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) communicable diseases, acquired immunodeficiency syndrome ("AIDS"), human immunodeficiency virus ("HIV"), (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) genetic testing, (8) laboratory test results, (9) other insurance coverage, (10) hazardous activities, (11) character, (12) general reputation, (13) mode of living, (14) finances, (15) occupation, and (16) other personal traits, if any such records exists.

Accordia Life & Ann Co (IA)
Allianz Life Insurance Co of North America
Allianz Life Insurance of New York
American General Life Insurance Co.
American National Insurance Company
Americo Financial Life & Annuity
Ameritas Life Insurance Corporation
Ameritas Life Insurance Corporation of NY
Ashar Group
Bankers Life & Casualty Company
Banner Life Insurance Company
Brighthouse Insurance Company
Brighthouse Insurance Company of NY
Charlotte A. Lee, M.D., P.A.
Cincinnati Life Insurance Co.
Columbus Life Insurance Co.
ECA Marketing Inc.
Fasano
Fidelity & Guaranty Life Insurance
Fidelity & Guaranty Life Insurance Co NY
First Symetra National Life Ins. Co of NY
Genworth Life Insurance Co.
Guardian Life Insurance Company of America
Guardian Insurance & Annuity Co Inc
John Hancock Financial
John Hancock Life & Health Ins (MA)
John Hancock Life Ins Co (USA) (MI)
John Hancock Life Ins Co of NY (NY) Kestra Insurance Services, LLC
Kestra Investment Services, LLC
Lenox Advisors Inc.
Lincoln Life & Annuity Co. of New York
Lincoln National Life Insurance Co.
Life Ins Co of the Southwest (TX)
Lombard Intl Life Assur Co (PA)
Lombard Intl Life Assur Co NY (NY)
LTCI Partners, LLC
Manulife Bermuda
Massachusetts Mutual Life Insurance (MA)
Minnesota Life Ins Co (MN)
MML Insurance Agency, LLC
Mutual of Omaha Ins Co (NE)
National Western Life Ins Co (CO)
National Life Ins Co (VT)
Nationwide Life & Annuity Insurance (OH)
Nationwide Life Insurance Co. (OH)
New York Life Insurance and Annuity (DE)
New York Life Insurance Co. (NY)
NFP Brokerage Insurance Services, Inc.
NFP Insurance Services, Inc.
North American Co for Life & Heath Ins (IA)
NYLIFE Insurance Co. of Arizona (AZ)
OneAmerica
Pacific Life Insurance Co (NE)
Pacific Life and Annuity Co (AZ)
Pan American Life
Pan American Life-Bermuda
Pan-American Life Ins Co (LA)
Pan-American Life Ins Co of PR (PR)
Penn Mutual Life Ins Co (PA)
Penn Insurance & Annuity Co (DE)
Penn Insurance and Annuity of New York
Principal Life Insurance Co (IA)
Principal National Life Insurance Co (IA)
Pro Financial Services, LLC
Protective Life & Annuity Ins (AL)
Protective Life Insurance Co (TN)
Pruco Life Insurance Co (AZ)
Pruco Life Insurance Co. of New Jersey (NJ)
Prudential Insurance Co. of America (NJ)
Prudential Life Insurance Co. of America (NJ)
Risk Righter
Savings Bank Mutual Life Insurance Co (MA)
Securian Life Ins Co (MN)
Security Mutual Life of NY (NY)
State Life Insurance Company (IN)
Succession Capital Alliance
Sun Life Bermuda
Symetra Life Ins Co (IA)
Symetra National Life Ins Co (IA)
Transamerica Bermuda
Transamerica Financial Life Ins Co (NY)
Transamerica Life Insurance Co (IA)
Transamerica Premier Life Ins (IA)
United of Omaha Life Ins Co (NE)
Unum Ins Co (ME)
United States Life Insurance in NY
William Penn Ins Co of New York (NY)
Windsor Insurance Associates, Inc.

Additional Insurers and Agencies

Proposed Insured initials _____

Authorization to Obtain and Disclose Confidential Information

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name _____

Physician Address _____

any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to the Insurers and Agencies listed afore and to:

Requestor of Medical Information: _____

Address: _____

Proposed Insured initials _____

Requestor of Medical Information: Windsor Insurance c/o EIS Processing Center

Address: P.O. Box 778, Torrance, CA 90508 / Phone: 888-846-8804 / Fax: 310-320-5031 / Email: records@ircopy.com

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my broker in writing. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at_____this_____day of_____,_____(year)

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X _____

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child: _____

Relationship of Representative to Minor: _____

Signature of Witness:_____

Authorization to Obtain and Disclose Confidential Information

NOTICE TO PROPOSED INSURED

Instructions to the Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES. EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.