Life Insurance: Fact Finder

NFI SOLUTIONS
NATIONAL FINANCIAL INS.

This is not an application for life insurance. The informal application is used exclusively to gather specific details on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.

Today's Date: ___________________________________

Agent Information (Required)

Name:_______________________________ Tel.#: _______________________________________

Social Security #: _____________________________E-mail: ____

Address: ___________________________________City: ____________________ State: _____ Zip: _______

Insured Information (Required)

Name: ____________________________________Date of birth:___________________ Male or Female

Address: ____

Primary tel. #: ______________________________Social Security #: ______________________________

Monthly income: ____________________________Total net worth: _________________________________

Occupation: ________________________________

Driver's license #:______________________State______

Expiration date: ______________________________

Are you a US Citizen: Yes or No

If no, Visa type: ____

Have you or do you intend to travel outside of the US in the past/next 12 months? Yes or No

If yes, please provide details of travel: ____

Plan Information

Plan of insurance you are inquiring about (circle):

Whole Life Universal Life Term Life: (Duration__________) Survivorship Variable

Face amount: ___________________ Premium budget: _________________

Premium mode: _______________ State of Sale (Signing State):________

Purpose of insurance: ____

Any life, disability, or annuity policies currently in-force?: Yes or No

Carrier	Face Amount	Year Issued	Premium	Replacement	Owner/Purpose

Has this case been submitted to other companies in the past 12 months? Yes No (If yes, please list below):

Company: ______________________________________Date submitted: ____

Action Taken: ____

Company: ______________________________________Date submitted: ____

Action Taken: ____

Company: ______________________________________Date submitted: ____

Action Taken: ____

Tobacco/Nicotine Use

Have you ever used any kind of tobacco product? Yes No

If yes, forms used (circle): Cigarettes Cigars Pipe Dip/chew Nicotine Gum E-Cigarette/vape

Other ____

Frequency: _____________________________________Date of last usage:______________________________

Drug/Alcohol Use

Do you currently drink alcohol? Yes or No

Date of last consumption: ___________________________________

Type of Alcohol: ______________________________ Frequency: ____

Type of Alcohol: ________________________________Frequency: ____

Have you ever consulted a doctor or received treatment for alcohol abuse? Yes or No

Have you ever been arrested for driving under the influence of alcohol? Yes or No (If Yes, date: _______________)

Have you ever used illegal drugs, consulted a doctor, or received treatment for drug abuse? Yes or No

Types of Drugs Used: ____

Date(s) Last Used: _____________________ Are you currently involved in a 12-Step Program? Yes or No

Marijuana Use

Have you ever used any kind of marijuana/CBD product? Yes or No

If yes, reason for use: Recreational Medicinal

Delivery method: Ingested Vaporized Smoked Other __________________________ Frequency: ____________________

Date of last usage: ___________________________________

If medicinal, reason prescribed ___________________Frequency: ____

Hazardous Activities

- Only complete if applicable

Are you a pilot? Yes No (If Yes, please provide details below):

How many total hours have you flown as Pilot in Command? _________ How many hours do you fly per year? ______

Are you IFR (Instrument Flight Rated)? Yes or No

Do you participate in any of the following activities? (circle all that apply)

Scuba Diving   Bungee Jumping   Ultralight Flying   Sky Diving   Mountain Climbing

Hang Gliding   Auto Racing   Motorcycle Racing

Other (details): ____

Medical Information

Height: ________ Weight: ________

Have you had any significant weight change (10 lbs. or more) over the last 12 months? Yes No

If yes, please explain reason for weight change: ____

Blood Pressure and Cholesterol:

Latest BP reading: _____ /_____Latest total cholesterol: _________ mg; Latest cholesterol/HDL ratio: _________

Have you ever had, been told you had, or been treated for any of the conditions listed in the below section? Yes or No

Doctor Information

Circle all that Apply: Dementia/cognitive impairment   Asthma   Cancer   Cirrhosis   COPD   Coronary artery disease

Cerebrovascular disease   Colitis or Crohn's disease   Depression/anxiety   Diabetes   Drug abuse

Heart murmur/valve disease   Hepatitis   Internal organ transplant   Irregular heartbeat/palpitations   Kidney disease

Lupus   Multiple sclerosis   Peripheral vascular disease   Rheumatoid arthritis   Seizure   Sleep apnea   Stroke or TIA

Other:____

Primary care physician's name: ____

Address: ____

Tel. #: ____

Date last seen: _______________________________ Reason for visit: ____________________________

Please list all doctors seen in the last 5 years along with reason for visit:

Name/specialty: ___________________________City, State: ___________________________________

Tel. #: __________________________________Date seen/reason: ___________________________

Name/specialty: ___________________________City, State: ______________________________

Tel. #: __________________________________Date seen/reason: __________________________

Name/specialty: ___________________________City, State: __________________________________

Tel. #: __________________________________Date seen/reason: ___________________________

Medication

Medication: ______________________________
Frequency: ______________________________
Quantity/Dosage: __________________________

Medication: ______________________________
Frequency: ______________________________
Quantity/Dosage: __________________________

Medication: ______________________________
Frequency: ______________________________
Quantity/Dosage: __________________________

Medication: ______________________________
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Medication: ______________________________
Frequency: ______________________________
Quantity/Dosage: __________________________

Medication: ______________________________
Frequency: ______________________________
Quantity/Dosage: __________________________

Family History

Has any immediate family member (parent/sibling) been diagnosed or died from heart disease, cancer, stroke or diabetes? Yes or No

If yes, please provide details:____

Relation: ___________________________________ Diagnosis: ____

Age at onset: _______________________________ Age at death (if applicable): ___________________________

Relation: ___________________________________ Diagnosis: ____

Age at onset: _______________________________ Age at death (if applicable): ___________________________

Relation: ___________________________________ Diagnosis: ____

Age at onset: _______________________________ Age at death (if applicable): ___________________________

Coronary Artery Disease - Only complete if applicable

Date of diagnosis or first chest pain: __________________ Number of Diseased Vessels: ____________________

Dates/details or treatments/surgery (example: Angioplasty, Bypass): ____________________________________

Date of last stress EKG: ____________________________ Results: ___________________________________

Physician that completed: ____

City/State of physician: ____________________________ Tel. #: _____________________________________

Any pain since treatment/surgery? Yes or No

Cancer - Only complete if applicable

Exact name and location of cancer: ____

Stage and grade: ____

Physician contact information to obtain pathology report: ____

Dates/details or treatment/surgery: ____

Diabetes - Only complete if applicable

Date of Diagnosis: ___________________________________

Treatment: (Circle all that apply)

Diet only Oral medication Insulin Other (specify) ____

Do you regularly test your blood for glucose? Yes or No Frequency: ____________ Avg Result: _____________

Latest result of glycohemoglobin (A1C) test: ____________ mg%

Have you ever had any of the following? (circle all that apply)

Eye Trouble Heart Trouble High Blood Pressure Kidney Trouble

Neuropathy/Neuralgia Insulin Reaction (Explain below) Protein/Microalbumin

Please provide any additional information you feel necessary to enhance the underwriting process.

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APS Request

NFI SOLUTIONS
NATIONAL FINANCIAL INS.

Client Information:

Clients Name:	Gender: Female Male
Address:	DOB:
Contact Number:	SSN:
Policy Type:	Policy Amount:

Doctors Information:

Doctors Name:	Facility Name:
Address:	Contact Number:

Agent Name: ______________________ Date: ______________

Authorization Form

This Authorization is HIPAA compliant

NFI SOLUTIONS
NATIONAL FINANCIAL INS.

Date: ____________ Advisor Name: __________________________ Advisor Phone: (______) ______________

Insured Name: __________________________ Maiden Name: __________________ Date of Birth: ___________

SSN: ________________________ Driver's License #: _______________________ State: __________________

The purpose of this Authorization is to permit NFI Solutions 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 listed below.

I specifically authorize any physician or other medical practitioner, hospital, clinic, or other health-related facility, medical testing laboratory, insurer, state motor vehicle department, my past or current employer(s), the Social Security Administration and any other organization, institution or person who has information or documentation about me to release such information and documentation to NFI Solutions, its authorized representatives and one or more of the insurers or other institutions listed below. The information and documentation to be released to NFI Solutions shall specifically include any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition including, but not be limited to, documents relating to my mental and physical health, mental health records, drug/alcohol abuse treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("Information").

Additionally, I specifically authorize NFI Solutions to release any and all Information it receives about me to the companies listed below. I also specifically authorize NFI Solutions and the companies listed below to release any and all Information about me to their respective re-insurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB*) to release any and all Information about me directly to any company listed below, upon such company's request, provided the company is a member of MIB.

This Authorization shall be effective for two (2) years after the date signed below. I understand I have the right to revoke this Authorization at any time by sending a written notice of revocation to NFI Solutions 16233 Kenyon Ave. Suite 220 | Lakeville, MN 55044. I understand any action taken in reliance on this Authorization prior to NFI Solutions' receipt of the written notice of the revocation shall be valid. I also understand any information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy rules.

I understand execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the companies below. I acknowledge that I have read and understand the above and agree this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Ash Brokerage and/or any third party designated herein.

____ ______________________________

ProposedInsured's Signature / Guardian, Custodian orAuthorizedRepresentative- Include Capacity   Date

AIG / American General/Corebridge
Allianz
American Equity
American National
Ameritas
Assurity
Athene Annuity
Baltimore Life
Banner Life
Colorado Bankers Life Equitrust
Fidelity & Guaranty
Foresters Financial
Global Atlantic Financial Group Great American
Guaranty Income Life Insurance
Guggenheim/Clearspring
Integrity LifeJohn Hancock LTC
Legacy Marketing Group
LMG Americo
LMG Ameritas
Lincoln National Life
Minnesota Life
Mutual of Omaha
National Guardian
National Western
Nationwide
North American
OneAmerica/State Life Principal Life Insurance Company
Protective Life
Prudential
Reliance Standard
Reliastar - TSA
Sagicor
Sentinel Security
Securian Life
Symetra
Transamerica Insurance Company
United of Omaha
Voya

NFI Solutions will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured.