Shaw American -INFORMAL PRE APPLICATION

First	Last	Mi	☐ Male ☐ Female	Date of Birth / Save Age?
Home Address				
City	State			Zip
Any Nicotine Usage ☐ Yes ☐ No	Explain types of nicotine usage. Please give dates if discontinued use in last 5 years.			Height _____ Weight _____
Face Amount	**Type Of Coverage**	Has the client been declined for coverage before? If so when and Why?		

Give full details if any answer to the following questions is "Yes" please provide dates, nature of illness or injury, number of attacks, duration, severity, treatment, and results. Provide any information important to your condition (s)

Medical Questions	**Please answer all questions Yes or No.**	**Please provide details for any questions marked yes**
	Yes No	
1. Has the proposed insured ever been told or treated for any of the following Diabetes, cancer, heart disease, stroke/ TIA, psychiatric or anxiety disorders, Aids/HIV, alcohol or drug problems or treatment, or any disorder of the lungs or respiratory system?	☐ ☐	
2. Does the proposed insured take or been advised to take any prescription or non-prescription medications?	☐ ☐	
3. Are there any scheduled or planned surgeries at this time?	☐ ☐	
General Questions		
4. In the past 5 years, have you had your license suspended or had a DUI/DWI or 2 or more moving violations or accidents?	☐ ☐	
5.In the past 5 years flown, or do you intend to fly, other than as a passenger?	☐ ☐	
6. In the past 2 years have you engaged in, or do you intend to engage in, any hazardous activities or sports such as hang gliding, hot-air ballooning, ultra-light flying, mountain or rock climbing, motor vehicle or boat racing, or scuba or sky diving?	☐ ☐	

	Age if Living	Age at Death	List Any Cardiac Conditions or Heart Disease and Age of Onset	List Any Cancer Diagnoses And age of Onset	Comments
Father					
Mother					
Siblings					

Agent Name _____

Telephone _____ Email _____

Shaw American Financial Corp. Authorization for Release Of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize **Shaw American Financial Corp** and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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 my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to **Shaw American Financial Corp**. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Shaw American Financial Corp and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Shaw American Financial Corp may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

_____	_____
Proposed Insured's Name	**Proposed Insured's Signature**
_____	_____
Signed and Dated On	**At (City, State, Zip Code)**

Agent/ Witness _____

AIG, American General Life Insurance Company, American National Insurance Companies, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, ING USA Annuity and Life Insurance Company, John Hancock, Lincoln Benefit Life, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Security Life of Denver Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, West Coast Life Insurance Company