EMG
Insurance Brokerage
An Insurance Designers member since 1987

ADVISOR NAME:
____
Phone # (________) _______________

DEATH BENEFIT/FACE AMOUNT:
TERM - $______________________
PERM - $______________________

10000 Memorial Drive ♦ Houston, TX 77024 ♦ 713-507-1000 ♦ FAX 713-507-1090

INFORMAL INQUIRY

Not an application for insurance

FULL NAME:	SEX:	DOB:	DL # / EXP DATE & STATE:	SSN:
CURRENT ADDRESS:			OCCUPATION & DUTIES:	

HAVE YOU USED ANY FORM OF TOBACCO? (Cigarettes, pipe, cigars, dip or chewing tobacco) **YES** **NO**
If yes, list type & amt or date quit:

1. **Have you been hospitalized for any reason in the last 5 years?** **YES** **NO**
   Advise reason, length of stay and any treatment/medications given as well as follow up completed and/or recommended.
   Details: ____
2. **Are you currently taking any prescription medications?** **YES** **NO**
   Please provide name, dosage and frequency of all prescribed medications.
   Details: ____
3. **Any family history of diagnosis, treatment or death due to heart disease or cancer?** **YES** **NO**
   Please provide whether a parent or sibling, condition and age at diagnosis or death.
   Details:____

LIST ALL DOCTORS – NAME & ADDRESS	DR PHONE #	DATE LAST SEEN & REASON FOR VISIT ANY TREATMENT OR MEDICATION PRESCRIBED

AUTHORIZATION TO OBTAIN INFORMATION

Please furnish: Insurance Designers of Houston, Allianz, American General, American National, AXA Equitable, Brighthouse Financial/MetLife, Cincinnati Life, Columbus Life, Global Atlantic, John Hancock, Life Insurance Company of the Southwest, Lincoln Financial, Minnesota Life, Nationwide, New York Life, North American Company, Pacific Life, Principal National Life, Protective Life, Prudential, SBLI, Symetra, Transamerica, United of Omaha, VOYA, Zurich American Life; or their legal representative and reinsurers any information.

Information regarding your insurability will be treated as confidential.

The Companies named above may also release file information to other life insurance companies where you may apply for life or health insurance, or to whom a claim may be submitted. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health, to give to the companies named above any such information. A photographic copy of the authorization shall be as valid as the original. By my signature, I indicate that we retained a copy of this information.

X ______________________________ ______________________________ ______________

Signature of Proposed Insured **Printed Name of Proposed Insured** **Date**

Proposed Insured Preferred Phone Number: (______) ______________________