Confidential Client Intake Form - Page 1 of 3
973-692-0088 - www.partnersresource.net

PARTNERS RESOURCE, LLC

PERSONAL HISTORY

Proposed Insured _____ ☐ Male ☐ Female

Street Address _____

City _____ *State* _____ *Zip code* _____

Date of Birth _____ *Social Security* _____

In search of….

- ☐ Universal Life
- ☐ Term
- ☐ Survivorship
- ☐ Premium Finance
- ☐ Life Settlement

FINANCIAL HISTORY

Occupation		Amount of Insurance	
Annual Income		Amount In force	
Total Net Worth		Replacement	
Purpose of Insurance		Preferred Carriers(s)	

FOREIGN TRAVEL / RESIDENCY

Are you a US Citizen? ☐ YES ☐ NO _____ *if not, please specify country*

If not a US Citizen, what type of Visa Authority do you have?	
In the last 12 months where have you traveled?	
How many weeks in the last 12 months have you traveled outside of the country?	
Do you anticipate traveling outside of the US in the next 12 months. If so, where and for how long?	

MEDICAL HISTORY

☐ Height ☐ Weight _____ *Have you experience more than a 10Lbs weight change in the last 12 months?*

List Current Medications

Family History	Age if Living	Age at Death	Cause of Death
Father			
Mother			

Have you ever smoked cigarettes or used any other form of tobacco? If yes, last date of use, type and frequency.	
Are you under treatment or taking medications for any medical condition?	
Have you ever applied for life insurance and been rated or declined?	
Have you ever received advice of treatment for tumor or cancer, brain, heart, lung, liver or kidney disorder, diabetes, stroke, high blood pressure, mental or nervous disorder, use of alcohol or drugs?	

PRIMARY CARE PHYSICIAN		DERMATOLOGIST	
Name		Name	
City & State		City & State	
Phone Number		Phone Number	
Date & Reason for last visit		Date & Reason for last visit	
CARDIOLOGIST		**OB/GYN**	
Name		Name	
City & State		City & State	
Phone Number		Phone Number	
Date & Reason for last visit		Date & Reason for last visit	
UROLOGIST		**NEUROLOGIST**	
Name		Name	
City & State		City & State	
Phone Number		Phone Number	
Date & Reason for last visit		Date & Reason for last visit	
PSYCHIATRIST		**OTHER**	
Name		Name	
City & State		City & State	
Phone Number		Phone Number	
Date & Reason for last visit		Date & Reason for last visit	

CORONARY ARTERY DISEASE

Date Diagnosed _____ Date Last Stress Test _____ Results Normal / Abnormal

Have you had any of the following

heart attack		(date)
coronary angioplasty		(date)
heart failure		(date)
CABG		(date)
valve surgery		(date)

CANCER - GENERAL

Type of Cancer _____ Date diagnosed _____ Stage/Grade _____

How was cancer treated?

surgery		(last day of treatment)
radiation		(last day of treatment)
chemotherapy		(last day of treatment)
hormonal therapy		(last day of treatment)
immunotherapy		(last day of treatment)

DIABETES

When diagnosed _____ Most recent A1C reading _____

Controlled by?

diet alone		
oral medication		(medication & doses)
insulin		(amounts of units/day)

ADDITIONAL COMMENTS

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance and/or settlement companies (which practice in the buying and selling of existing life insurance) named below, their reinsurers, any insurance support organizations, and the representatives of these companies may need to collect information on me in regard to my existing and/or proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance, reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person to furnish to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. I authorize my current insurance company to furnish Partners Resource, LLC and/or its authorized representatives with any information and forms in connection with my policy including any conversions or replacements thereof.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit or other personal traits. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional, or insurance functions for the life insurance and/or settlement companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization and that I may revoke my consent at any time by sending written notice of my revocation to Partners Resource, LLC I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications, prescribed, and any other protected health information concerning me to the insurance companies and/or settlement companies named below. 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 to restrict my protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. This protected health information is to be disclosed under this Authorization so that the companies, insurance, settlement, or other named below may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibilities for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the insurance and/or settlement companies named below.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is a valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Partners Resource, LLC, at 58 Franklin Avenue, Franklin, NJ 07416. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that the insurance and/or settlement companies named below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the insurance companies and/or settlement companies named below except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization or release my complete medical record, the companies, insurance, settlement, or others named below may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this Authorization upon request.

21st Services	The Hartford	Old Mutual Fin. Network
Advantage Insurance Network, Inc.	ING/Reliastar/Security Connecticut Life	Parameds (PDC)
Advanced Settlements, LLC	ING/Security Life of Denver	Principal Life Insurance
Allianz	John Hancock Life Insurance Company	Protective L&A of NY
Allstate of New York	John Hancock Variable Life Insurance	Protective Life Insurance
American General	John Hancock (USA)	Prudential (PRUCO of NJ)
American National (ANICO)	John Hancock Life of New York	Security Mutual
American Viatical Services, LLC (AVS)	Lincoln Benefit Life Insurance	Sun Life of Canada
AXA/Equitable Life Insurance	Lincoln Life & Annuity of New York	Sun Life of New York
Aviva	Lincoln National Life Insurance	Stonegate Brokerage
Banner Life Insurance	Mediconnect	Symmetry Life Settlements
Broker Advantage	Metropolitan Life Insurance	Synergy Life Brokerage
Capital Brokerage	Metlife Investors	Transamerica Life Insurance
Companion Life Insurance	Mutual of Omaha	Transamerica Occidental Co.
EMSI	Nationwide Life Insurance	Union Central Life Ins
First MetLife Investors	Nationwide Life & Annuity Company	United of Omaha
Genworth Life	New York Life Insurance	United States Life
Genworth Life & Annuity	Ohio National Life Insurance	West Coast Life
Genworth Life of New York	New York Life Insurance	William Penn Life Insurance

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