

INFORMAL INQUIRY

Client's Name(s):	D.O.B.:	US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Social Sec. # :
-------------------	---------	---	-----------------

Resident Address: _____

Client's Name(s): <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	Weight:
--	---	---------	---------

Agent's Name	Agent's Phone	Fax	Agent's SS#/Tax I.D.	Agent's Email Address
--------------	---------------	-----	----------------------	-----------------------

Plan of Insurance / Amount Desired: \$ _____	How much life insurance currently inforce?	Premium Tolerance
--	--	-------------------

Has case been *submitted* to other companies in the past 6 months? Yes No
 If yes, list companies, file #s, dates submitted and offers made:

Company: _____ File # _____ Date: _____
 Company: _____ File # _____ Date: _____

List any Insurance applied for that was *rated or issued* other than applied for:

Name of Company	Amount	Year	Issued?	Std. Premium	Extra Premium	Reason Rated or Declined

Currently use any tobacco product, or ever use? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide details, (type and how long) Details: _____	If discontinued date stopped: _____/_____/_____
---	--	--

Family History:	Age of living	Present Health	Age of Death	Cause of Death
Father:				
Mother:				
Brother(s):				
Sister(s):				

* What physician(s) have you consulted in the past 10 years?

Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ Reason: _____	Physician(s) name: _____ Date: _____ Phone numbers: _____ Address: _____ Reason: _____
--	--

* In what hospitals, clinics, etc. have you ever been treated?

Physician(s) name: _____ Hospital/clinic/etc.: _____ Phone numbers: _____ Address: _____ Reason: _____ Date: _____	Physician(s) name: _____ Hospital/clinic/etc.: _____ Phone numbers: _____ Address: _____ Reason: _____ Date: _____
--	--

* Please list all medications

_____	_____
_____	_____

*Please provide additional details on a separate page.



Client's Name(s)	Soc. Sec. #
------------------	-------------

CORONARY—Check here if this section is NOT applicable

1. Date of diagnosis of first chest pain: ____ / ____ / ____
2. Number of diseased vessels: _____
3. Dates/details of treatment/surgery (examples: Angioplasty, Bypass)

4. Date of last stress EKG: ____ / ____ / ____ Results: _____
 By whom: _____
5. Any pain since treatment/surgery? _____

CANCER—Check here if this section is NOT applicable

1. Exact name and location of cancer: _____

2. Stage and grade: _____
3. Who would have the pathology report?: _____
4. Dates/details of treatment/surgery: _____

DIABETES—Check here if this section is NOT applicable

1. Date of diagnosis: ____ / ____ / ____
2. Treatment: (check one) Diet Only Oral Medication Insulin
 Details: _____
3. Do you regularly test your blood glucose?: Yes / No
 Results: _____ Frequency: _____
4. Latest result of glycohemoglobin (A1C) test: _____ mg%
5. have you been diagnosed with having protein and/or microalbumin in your urine?: Yes / No
6. Have you ever had?

a. Any eye trouble? <input type="checkbox"/> Yes / <input type="checkbox"/> No	d. Kidney trouble? <input type="checkbox"/> Yes / <input type="checkbox"/> No
b. Heart trouble? <input type="checkbox"/> Yes / <input type="checkbox"/> No	e. Neuritis/neuralgia? <input type="checkbox"/> Yes / <input type="checkbox"/> No
c. High blood pressure? <input type="checkbox"/> Yes / <input type="checkbox"/> No	f. Insulin reactions? <input type="checkbox"/> Yes / <input type="checkbox"/> No

Have you ever sought treatment for Alcohol or Drug Abuse?—Check here if this section is NOT applicable

Yes / No (If yes, please request the appropriate questionnaire)

HAZARDOUS ACTIVITIES—Check here if this section is NOT applicable

Yes / No (If yes, please check the activity and request the questionnaire)

<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Ultralight Flying	<input type="checkbox"/> Sky Diving
<input type="checkbox"/> Mountain Climbing	<input type="checkbox"/> Hang Gliding	<input type="checkbox"/> Auto/Motorcycle Racing	<input type="checkbox"/> Other

MADISON BROKERAGE CORPORATION

65 MADISON AVE., STE 200, PO BOX 1940
MORRISTOWN, NJ 07962-1940

Phone: 973.539.3232 Toll Free: 888.539.3232 FAX 973.539.3737
EMAIL: sales@madisonbrokerage.com

AUTHORIZATION FOR DISCLOSURE - HIPAA Compliant

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider ("Authorized Disclosure") to provide to Madison Brokerage Corp and/or its affiliates, directors, officers, employees, service providers or other representatives noted below ("Madison Brokerage"), any and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past, present or future physical or mental history or condition. I also specifically authorize each Authorized Disclosure to release to Madison Brokerage the results of any HIV or AIDS test as well as information relating to any sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed here under will be treated as confidential and will only be used by Madison Brokerage in connection with the decision to purchase, finance, transact a life settlement and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain healthcare benefits (treatment, payment or enrollment).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Disclosure by notifying such Authorized Disclosure of my revocation of this authorization in writing and delivery of said revocation by mail or personal delivery at such address designated by Authorized Disclosure; provided that any revocation of this Authorization shall not apply to the extent that (i) the Authorized Disclosure has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

I understand that this Authorization is not a consent or an authorization requested by a health care provider, health care clearing house or health plan covered by privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Regulations"). I further understand that, as a result of this Authorization, any of my medical information disclosed by any Authorized Disclosure to Madison Brokerage may be redisclosed by Madison Brokerage and may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this Authorization freely and unilaterally as of the date written below and that all information contained herein is true, accurate and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a signed copy of this Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Disclosure to rely upon a photostatic or facsimile copy or other reproduction of this Authorization the same as the original.

This Authorization shall remain valid until, and shall expire on the date one year following the date of my death.

AIG-American General / Abacus Settlements, LLC / Allianz / All Financial / Allstate Life of NY / American Mayflower / American National /Applied Capital / AVS Underwriting / AXA / Banner Life / Bankers Life of NY / Berkshire Settlements/ Berlin Atlantic Capital / Clearwater Settlements / Columbus Life / Companion of NY/ Coventry First / EMSI / Exceptional Risk Advisors / Fair Market Life / Fasano / First Colony Life Genworth Companies / First Equity Benefits / Great West Growth, LLC / Greenwich Life Settlements / Habersham Funding / Hartford / ICS Services / ING Companies / Indianapolis Life / Independent Funding Group, LLC / Insurative Premium Finance (Jersey) Limited / Integrity Settlement Providers / Jefferson Pilot / John Hancock / Legacy Benefits / Liberty Life / Life Equity, LLC / Life Exams / Life Settlement Providers, LLC / Life Settlement Solutions / Life trust, LLC / Lincoln Benefit / Lincoln Life / Living Benefits / Magna Administrative Services / Maple Life Financial / Met Life / Milestone Managers and Providers / Minnesota Life / Montage Financial Group / National Western Life / Nationwide / Neuma, Inc / New Life Capital Strategies / New York Life / North American / Old Mutual Financial Network / Pacific Life / Peachtree Life Settlements / Phoenix / Portsmouth Settlement / Presidential Life / Principal Financial / Progressive Capital Solutions, LLC / Proverian Capital, LLC / Prudential / Q Capital Strategies / RAI Group / Reliastar Life Ins Co / Reliastar Life of NY / SBLI / Secondary Life Capital, LLC / Senior Settlements / Seven Hills Settlements / 21st Services / Security Life of Denver / Silver Point Capital / Standard Insurance Company / Sun Life / Sun Life of NY / The Ardan Group / Transamerica / United of Omaha / Universal Underwriters Life Ins / U.S. Financial / US Life / Vespers / ViaSource Funding Group, LLC / West Coast Life / William Penn / Wm. Page & Assoc (Lifeline) / ZURICH

Name of Insured _____ Signature _____

Date of Birth _____ Social Security Number _____ Date _____