MILNER
FINANCIAL
AN INTEGRITY COMPANY

2500 Daniells Bridge Road,
Building 100
Athens, GA 30606
770-404-0000 800-700-7474
www.milnerfinancial.com

This Trial Application is for policies with premium greater than $5,000.

BASIC APPLICANT INFORMATION

Last Name	First	M.I.	DOB

SS#	Gender M ☐ F ☐	Height	Weight

Occupation	State of Sale	Lost weight in last year? Lbs.

Are you a citizen of the United States? Yes ☐ No ☐ If no, please list Visa.green card type.

Have you ever used tobacco in any form? Yes ☐ No ☐ If yes, give type of tobacco, frequency, and date last used.

INSURANCE INFORMATION

Amount of Insurance Desired	Plan/Type of Insurance

Please provide plan, company and amount of insurance in force.

Replacing? Yes ☐ No ☐

Will a 1035 be involved? If Yes, please list the 1035 amount.

What is the budgeted premium for this policy or the price we need to beat?	Details of competition from other agents or companies.

Has the applicant applied to another company in the last 6 months? Yes ☐ No ☐ If yes, please give details.

Purpose of insurance?	Please list any special time restraints involved with this case.

MEDICAL HISTORY

What medical conditions do you now have and when were you diagnosed with them?

Who is your personal physician? (Provide Doctor's name, address, and phone number) How long has this doctor been your primary care physician?

What other physicians have you consulted during the past five years? When were they consulted and why?

Have you ever been hospitalized or seen in the emergency room? If so, please list facility, reason seen, and date.

Please list all prescribed and over-the-counter medications you currently take, and which physician prescribes them (if you see more than one doctor).

AGENT INFORMATION

Agent Name	Agent phone #

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Milner Financial, its affiliated agencies, including but not limited to Verisk Health/Mediconnect, Parameds.com, EMSI, Jetstream, ExamOne, and ProScan Partners _____ ,hereby referred to as "my agent", 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, the Department of Motor Vehicles, or other health care provider that has provided treatment or services to me or on my behalf within the past 20 years ("my Providers") to disclose my entire driving and medical records 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 agent and its staff, affiliated companies and/or entities, including but not limited to Verisk Health/ Mediconnect, Parameds.com, JetstreamAPS, 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 driving and 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 driving and medical records without restriction to Milner Financial. 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.

In furtherance of my above acknowledgments regarding release of my driving and medical records and any associated HIPAA protected health information and in an effort to process my application in an efficient and timely manner, I hereby authorize Milner Financial to use my below signature on any and all HIPAA authorizations to my health care providers required to underwrite and/or process the life insurance application submitted through the above referenced agent. I understand that I can revoke use of my signature at any time. In exchange for use of my signature on any required HIPAA authorizations, Milner Financial will send me a copy of all such authorizations.

☐ Check for Acknowledgment

The information contained in these driving, 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 reinsurers as well as Milner Financial 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 agent or Milner Financial at 2500 Daniells Bridge Road, Athens, GA 30606, to revoke this authorization and that the revocation will take effect when my agent 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, Milner Financial 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 _____

American General/ AIG
American National
Americo
Ameritas
Assurity
Accordia Life
AXA/Equitable
Banner/LGA
Cincinnati Life
Coventry
EMSI
ExamOne
General RE Life Corp
Guardian
Habersham Funding
Human API
ING/Reliastar/SLD
BU
John Hancock
Life Ins. Settlements, Inc
Life of the Southwest
Lincoln National
Lloyd's of London
Mass Mutual
Minnesota Life
National Life Group
NACOLAH
Nationwide
NewYork Life
One America
PAC Life
PennMutual
Principal Life Ins. Co.
Principal Nat'l Life
ProScan Partners
Protective Life
Prudential
Sagicor
SBLI
Securian
Symetra
Transamerica
Union Central
United of Omaha
Welcome Funds
Zurich