Oxbow
MARKETING COMPANY

www.oxbowmkt.com oxbowmkt.usfli.com
3053 Nationwide Parkway, Brunswick, OH 44212
330/273-4870 800/843-3057
Fax: 1-800/692-6932 or 330/273-8509

IF DIABETIC OR CARDIAC CASE, PLEASE COMPLEE APPROPRIATE FORM ON REVERSE SIDE.

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INFORMAL INSURABILITY INQUIRY

PLEASE COMPLETE ALL QUESTIONS IN FULL

FULL NAME (PRINT)		PLAN OF INSURANCE ☐ ADB ☐ WP	AMOUNT DESIRED $
DATE OF BIRTH	PLACE OF BIRTH	BENEFICIARY (Name & Relationship)	
RESIDENT ADDRESS		HOW MUCH INSURANCE IN FORCE NOW?	
MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐		HEIGHT: _____ FT. _____INCHES WEIGHT: _____ LBS.	
OCCUPATION _____		Has case been submitted to other companies in past 6 months? Yes ☐ No ☐ If yes, list companies, dates submitted, and offer.	
EMPLOYER _____			
ADDRESS_____			

FAMILY HISTORY (Important)

Relation	Age if Living	State of Health or Cause of Death	Age at Death
Father			
Mother			
Brothers & Sisters			

LIST ANY INSURANCE APPLIED FOR THAT WAS DECLINED OR RATED:

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

	NAME, ADDRESS, TELEPHONE #	REASON	DATE
What physician did you last consult? (Other than insurance examination)			
What physicians have you consulted during the past 10 years?			
In what hospital, clinics, or sanitariums have you ever been treated?			
Who is your personal physician? When did you last consult him?			

HAVE YOU USED ANY TOBACCO PRODUCTS IN THE PAST 12 MONTHS? ☐YES ☐NO
What kind and how much?_____

IS THIS INQUIRY TO REPLACE EXISITING COVERAGE? ☐ YES ☐ NO
REMARKS:_____

Agent _____ Address _____

Telephone No. ( )_____ _____

I hereby authorize any licensed physician, medical practioner, hospital, clinic or other medically related facility, insurance company, the Medical Informatin Bureau or other organization, institution or person, that has any records or knowledge of me or my health, to give to the Life Insurance Companies listed on this form at the time of my signature any such information. A photographic copy of this authorization shall be valied as the original.

We represent:

American General	Great American	Old Republic	Southland Life
Boston Mutual	Guarantee Trust Life	Peoples Benefit Life	State Life
Fidelity & Guarantee	Jefferson-Pilot	Reliastar Life	U.S. Financial
First Penn-Pacific	Old Line Life	Security-Connecticut	

I have received the Notice of Exchange and Fair Credits Act.

Veterans Administration Case No.

C-- _____ _____ _____
Date Proposed Insured MUST Read Authorization and Sign

INSTRUCTIONS TO AGENT: The notice below must be detached and given to the Proposed Insured before or at the time of signature.

NOTICE OF EXCHANGE OF INFORMATION

The information regarding your insurability will be treated as confidential. However, the Life Insurance Companies listed on this form at the time of my signature may make a brief report to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange for it's members. If you apply for life or health insurance to another company which is also a member of the Bureau or if a claim for benefits is submitted to such a company, the Bureau will, upon request, supply the information in it's file to that company. The Life Insurance Companies listed on this form at the time of my signature may also release information in its file, including information given your application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex-Station, Boston, Massachusetts 02112.

FAIR CREDIT REPORTING ACT NOTICE

The Life Insurance Companies listed on this form at the time of my signature may secure personal interviews with third parties such as family members, business associates, financial source, friends, or others with whom you are acquainted with concerning your character, general reputation, personal reputation, personal characteristics and mode of living. Upon written request, additional information will be provided as to the nature and scope of the report, if one is made.

We represent:

All American Life	Great American	Metropolitan	Southland Life
American General	Great Southern	Old Line Line	Southwestern Life
Boston Mutual	Guarantee Trust Life	Old Republic	State Life
Commonwealth Life	Jefferson-Pilot	Prudential	U.S. Financial
First Penn-Pacific		Security-Connecticut	

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COMPLETE APPLICABLE STATEMENT BELOW ONLY IF DIABETIC OR CARDIAC CASE

APPLICANT'S DIABETIC QUESTIONNAIRE

Full Name _____ Date of Birth _____
Residence Address _____
Height _____ Weight _____ Weight two years ago _____ Date diabetes diagnosed _____
Name and address of doctor who made the diagnosis _____

_____
Are you receiving treatment or under medical supervision now? _____
Give name and address of the doctor _____

_____
Do you ever stop the insulin or go off diet? _____ Is urine sugar free: (a) Now? _____ (b) Always? _____ (c) Date of last test? _____
Have you had any blood sugar estimations done? _____ If so, when and what were the fast estimations? _____
State amount of insulin taken daily _____ units _____
Type: Regular or Plain _____ units _____ Globin _____ units _____
Protamine Zinc _____ units _____ Time of administration _____
Have you ever had any infections, such as boils, abscessed teeth, tonsillitis, etc.? _____
Specify _____
Have you ever had any eye trouble? _____ Have you ever had any high blood pressure? _____
Have you ever had any heart trouble? _____ Have you ever had any recurring or prolonged illness? _____
Has an electrocardiogram been taken? _____ Date _____
By Whom? _____
If cardiogram taken, please submit same. It will be returned. _____ Was the electrocardiogram reported normal? _____
Has an x-ray of the chest been taken? _____ Date _____
By Whom? _____
Was the x-ray reported normal? _____

Date _____ Signature _____

APPLICANT'S CHEST PAIN QUESTIONNAIRE

(Please enclose all availabale Electrocardiogram tracings)

Full Name _____ Date of Birth _____
Residence Address _____

A. Have you ever experienced any of the following?	YES	NO
1. Chest Pain?	☐	☐
2. Palpitation?	☐	☐
3. Shortness of Breath?	☐	☐
4. Other Chest Discomfort?	☐	☐

B. Did Chest Pain involve:	YES	NO
1. Middle of Chest?	☐	☐
2. Left side of Chest?	☐	☐
3. Left Shoulder, Arm or Head?	☐	☐
4. Both Shoulders or Arms?	☐	☐
5. Sense of Pressure or Constriction?	☐	☐

C. Was it associated with:	YES	NO
1. Exertion? Exercise?	☐	☐
2. Excitement? Strain?	☐	☐
3. Meals?	☐	☐

D. If any of the above answered "yes", complete the following questions:
1. Approximate date of first pain? _____
2. Date of last pain? _____
3. How frequently did the pains occur? _____
4. Duration of Pains? _____
5. Hospitalized? How long? _____
6. Confied at home? How long? _____
7. Convalescent? How long? _____
8. Date of return to work? Restrictions? _____
9. What medicine is taken now? _____
10. When was the last Electrocardiogram taken? _____
By Whom? _____
11. What diagnosis was made concerning the heart condition? _____
_____
_____

E. Give names and addresses of all physicians consulted: _____

Date _____ Signature _____

INSTRUCTIONS TO AGENT: The notice on the reverse side must be detached and given to the Proposed Insured before or at the time of signature.