Simplicity Des Moines (formerly Davis Life & Annuity)
4949 Pleasant St, Ste 204
West Des Moines, IA 50266
www.SimplicityDesMoines.com|Tel. 800-747-5612| Fax 888-618-7444

Preliminary Underwriting Questionnaire

Please take a few moments to complete all section of this questionnaire.
We will be better able to help if we have the most current and accurate information possible.

Section 1…Proposed Insured Information

Full Name ________________________________Age ______Date of Birth _____/____/________

Sex ______ Height ______ Weight ______ Place of Birth______________ Marital Status________

SSN/Tax ID Number __________________Employer & Occupation ________________________
Home Address____ Unit/Apt ____________

Driver's License Number ____________________________License State___________________

US Citizen __________ If No, Date of Entry ___________Type of Visa_______________________
____

Section 2…Current and Desired Coverage Information

Amount of Coverage Requested ____________________Type of Coverage Term UL WL

Owner _____________________________Relationship to Insured ______________________

Beneficiary ________________________ Relationship to Insured ________________________

Annual Income ______________________Net Worth _________________________________

Please List All Current Coverage Below:

Company ___________________Face Amount _________Issue Year _____Cash Value ________
Will This Policy Be Replaced ___________

Company ___________________Face Amount _________Issue Year _____Cash Value ________
Will This Policy Be Replaced ___________

Company ___________________Face Amount _________Issue Year _____Cash Value ________
Will This Policy Be **Replaced** ___________

Has the Proposed Insured ever been denied, rated or had to postpone any life insurance coverage? _________
If yes, please complete the information below

Company _____________________________Rated / Declined / Postponed Year ____________
Reason____

Company _____________________________Rated / Declined / Postponed Year ____________
Reason ____

Company _____________________________ Rated / Declined / Postponed Year ____________
Reason ____

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Preliminary Underwriting Questionnaire and Authorization

Information and Instructions

Thank you for taking the time to complete the following pages. It is our goal to get the best possible offer for your client. In order to do that we need to have the most current health and lifestyle information regarding the proposed insured. After all pages have been Completed and signed, please scan and e-mail them to your life marketer or fax them to:

Attention: Life New Business Coach
Fax Number: 888-618-7444
Email: DSM.lifenewbusiness@simplicitygroup.com

Please allow 48 hours for someone to contact you regarding this case.
If you are unsure of the email of your life new business coach, please call 800-747-5612 for assistance.

Submitting Agent Information		
Name	Telephone	Ext
Address		Unit
City	State	Zip
Fax	E-mail	
Are you shopping this case? YES NO		
If YES, what companies have you submitted or are you going to submit this case to? Based on your client's history what offer are you expecting?____________________ What is the best way to contact you?____________________		

Section 3…Medical History

Please check Yes or No for all questions.

If yes answer applies to any questions, please provide details, such as: date of first diagnosis, name and address of doctor, test performed, test results, medication(s) recommended, and any treatment information in the area provided.

1. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:
   A. Heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? **YES___** **NO___**
   B. A blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? **YES___** **NO___**
   C. Cancer, tumors, masses, cysts or other such abnormalities? **YES___** **NO___**
   D. Diabetes, a disorder of the thyroid or other glands, or a disorder of the immune system, blood or lymphatic system? **YES___** **NO___**
   E. Colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestines? **YES___** **NO___**
   F. A disorder of the kidneys, bladder, prostate or reproductive organs of sugar or protein in the urine? **YES___** **NO___**
   G. Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder? **YES___** **NO___**
   H. Seizures, a disorder of the brain of spinal cord, or other nervous system abnormality including a mental or nervous disorder? **YES___** **NO___**
   I. Arthritis, muscle disorder, connective tissue disease or other bone or joint disorders? **YES___** **NO___**
2. Has the Proposed Insured in the past three years had but not sought treatment for:
   A. Fainting spells, nervous disorder, headaches, convulsions or paralysis **YES___** **NO___**
   B. Any pain or discomfort in the chest or shortness of breath? **YES___** **NO___**
   C. Disordered of the stomach, intestines, or rectum or blood in the urine? **YES___** **NO___**
3. What is the Proposed Insured's Height _______________ Weight _____________
4. Is the Proposed Insured currently under treatment, therapy, or medical observation? **YES___** **NO___** If YES, Please explain:

   ____

   ____
5. Please list all medications and dosages:

   ____

   ____

   ____

6. Has the Proposed Insured had a positive test for COVID-19 within the past six months? Please list dates and treatment sought: ______________________________

____

Please explain any questions answered YES above:

____

____

Section 4…Lifestyle Information

1. Has the Proposed Insured used tobacco of any form in the past 24 months? **YES___** **NO___**
   If YES, please list date of last nicotine use _____________Type of Tobacco ________________________
   Are you currently using nicotine gum or patch? **YES___** **NO___**

2. Has the Proposed Insured ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? **YES___** **NO ___**

3. Has the proposed Insured ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? **YES___** **NO___**
   If YES is answered to questions 2 or 3, please complete a Drug/Alcohol Questionnaire

4. Does the Proposed Insured engage in regular physical exercise other than which occurs during their work? **YES___** **NO___**
   Type of exercise Number of time each week For how many minutes
   ____
   ____

5. Is there a history of diabetes, stroke, heart disease, high blood pressure of kidney disease among the Proposed Insured's parents or siblings? **YES___** **NO___**
   Age, if living Health Age at Death Cause of Death
   Father ____
   Mother ____
   Brother/Sister ____
   Brother/Sister ____

6. In the past three years, has the Proposed Insured been in a motor vehicle accident, been charged with a moving violation, or had their license restricted or revoked? **YES___** **NO___**
   If YES, please explain____
   ____

7. Does the Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? **YES___** **NO___**
   If YES, please list country, date, length of stay and purpose ______________________________
   ____

Section 5…Physician Contact Information

Applicant's Personal Physician ________________________________Telephone __________________

Name of Clinic ____

Address ____Suite _____________

City ____State _____________ Zip ____________________

Date of Last Visit _______________________________________

Reason for visit? ____

Please list any other physicians, clinics, hospitals, or sanitariums the Proposed Insured has consulted with or been a patient of within the last five years on a separate piece of paper.

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HIPPA AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Applicant's Name: ____

Address: ____

____

City: ________________________________State: ____________________ Zip: ________________

Telephone: _____________________________________

Date of Birth: ___________________________________

SSN: ____________-_____________-___________________

DURATION: This authorization shall become effective immediately and shall remain in effect until _____________________________ or two years from date of signature.
(Date)

EVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the Requester may not lawfully further use of disclose the health Information unless another authorization is obtained from me or unless such use or Disclosure is specifically required or permitted by law.

PURPOSE: To obtain life insurance.

____ __________________________________
Signature of Proposed Insured or Representative Date

____
Print Name of Proposed Insured or Representative

____ __________________________________
Relationship to Insured or Legal Authority
(Attach supporting documentation)

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Authorization to Obtain Information
Waiver and Acknowledgment form

AUTHORIZATION:

I AUTHORIZE ______________________, OR any health plan, physician, health care professional, Hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider (MY Providers) that Has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Simplicity Des Moines and its agents, employees, And representatives. 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected Health information and I instruct My Provide4rs to release and disclose my entire medical record without Restriction.

I UNDERSTAND my protected health information is to be disclosed under this authorization so the SIMPLICITY DES MOINES may: 1) underwrite my application for coverage by making eligibility, risk rating, Policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally Permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below.

Accordia/Global Atlantic Life Insurance		Allianz Life Insurance Company		American General Life Insurance Co	
American National Insurance Company		Ameritas Life Insurance Company		Assurity Life Assurance Company	
Athene Annuity & Life Insurance Co		AXA Equitable Life Insurance Company		Banner Life Insurance Company	
Equitrust Life Insurance Company		Fidelity & Guaranty Life Insurance Company		Foresters Life Insurance Company	
John Hancock Life Insurance Company		Life Insurance Company of the Southwest		Lincoln National Life Insurance Company	
Metropolitan Life / Brighthouse		Minnesota Life/Securian Life Insurance		National Western Life Insurance Co	
Nationwide Life Insurance Company		New York Life Insurance Company		North American Co for Life and Health	
One America Life Insurance Company		Principal Life Insurance Company		Protective Insurance Co of America	
Prudential Life Insurance Company		Sagicor Life Insurance Company		Symetra Life Insurance Company	
SBLI – Savings Bank Life of Massachusetts		Transamerica Life Insurance Company		United of Omaha Life Insurance Co	
Other:		Other:		Other:	

This authorization shall remain in force for 24 months, beginning ____________________. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above-named facility or Simplicity Des Moines, 4949 Pleasant, Ste 204, West Des Moines, IA 50266. I understand that a revocation is not effective if any of My Providers has relied on this authorization or to contest the policy/certificate itself. 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.

WAIVER AND ACKNOWLEDGMENT

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant') in favor of Simplicity Des Moines, its successors, assigns, shareholders, directors and employees (collectively "Simplicity Des Moines").

Applicant acknowledges, understands and agrees as follows:

- That Applicant has filed an application with Simplicity Des Moines intending to secure life insurance from one or more insurance underwriters.
- That, in the course of applying for life insurance coverage, Simplicity Des Moines has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- That Simplicity Des Moines will provide that information, or parts of it, to a number of potential insurers and their agents, employees, and representatives.
- That Simplicity Des Moines maintains, or will maintain, and electronic data interchange (the "Interchange") through which certain Authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- That Simplicity Des Moines will use the Interchange to store some or all of the confidential and personal information Applicant has provided to Simplicity Des Moines, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- That the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- That, even though Simplicity Des Moines has in place security measures, Simplicity Des Moines believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though Simplicity Des Moines will continue to upgrade those security measures from time to time as circumstances warrant, Simplicity Des Moines can make no guarantee as to Simplicity Des Moines' ability to protect the Interchange and the information it contains from unauthori9zed access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
- That Simplicity Des Moines cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
- That Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in Simplicity Des Moines' possession and/or stored on the Interchange.
- That Applicant will indemnify Simplicity Des Moines for all costs and expenses incurred by Simplicity Des Moines or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Applicant has evidenced his/her acknowledgment, understanding, and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I have received a copy of this document.
I AGREE this form shall be valid for twenty-four (24) months from the date shown below.

Signed on this date: _______/ _______/ _______ City: ________________________State ________________

X ____ X ____

Signature of Proposed Insured/Parent or Guardian Signature of Witness

____

Printed Name of Proposed Insured/Parent or Guardian HIPAA Privacy Rule Compliant