



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.lifewbusiness@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 or 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 or 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.

REDISCLASURE: 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)



**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.

Allianz Life Insurance Co.	American General/Corebridge Life Ins. Co.	American National Insurance Company
Ameritas Life Insurance Company	Assurity Life Assurance Company	AXA/Equitable Life Insurance Company
Banner Life Insurance Company	Cincinnati Life Insurance Company	Columbus 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 Financial Group
MassMutual Life Insurance Co.	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:

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 unauthorized 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 _____
Signature of Proposed Insured/Parent or Guardian

X _____
Signature of Witness

Printed Name of Proposed Insured/Parent or Guardian

HIPAA Privacy Rule Compliant