INFORMAL INQUIRY

Client's Name(s):	D.O.B.:	US Citizen: ❑ Yes ❑ No	Social Sec. # :
Resident Address:			
Client's Name(s): ❑ Married ❑ Single ❑ Divorced ❑ Widowed	Sex: ❑ Male ❑ 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
Currently use any tobacco product, or ever use? ❑ Yes ❑ No	If yes, provide details, (type and how long) Details:	If discontinued date stopped: ____/____/____

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

❑ * 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.

Guidon Financial, LLC
5 Timberline Court
Millstone, NJ 08535
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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? ❑ Yes / ❑ No
   b. Heart trouble? ❑ Yes / ❑ No
   c. High blood pressure? ❑ Yes / ❑ No
   d. Kidney trouble? ❑ Yes / ❑ No
   e. Neuritis/neuralgia? ❑ Yes / ❑ No
   f. Insulin reactions? ❑ Yes / ❑ 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)

❑ Scuba Diving ❑ Bungee Jumping ❑ Ultralight Flying ❑ Sky Diving
❑ Mountain Climbing ❑ Hang Gliding ❑ Auto/Motorcycle Racing ❑ Other

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AUTHORIZATION FOR DISCLOSURE - HIPAA Compliant

I hereby authorize each physician, doctor, physician practice group, nurse, hospital, pharmacy, pharmacy benefit manager, pharmacy related service organization or medically related facility and/or any other health care provider ("Authorized Disclosure") to provide to Guidon Financial, LLC and/or its affiliates, directors, officers, employees, service providers or other representatives noted below ("Guidon Financial, LLC"), 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 Guidon Financial, LLC 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 Guidon Financial, LLC 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 Guidon Financial, LLC may be redisclosed by Guidon Financial, LLC 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 / Accordia Life / Allianz / Allstate Life of NY / American Mayflower / American National /Applied Capital / AVS Underwriting / AXA / Banner Life / Bankers Life of NY / Berkshire Settlements / 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 / Insurative Premium Finance (Jersey) Limited / John Hancock / Legacy Benefits / Liberty Life / Life Equity, LLC / Life Exams / Life Settlement Solutions / Life trust, LLC / Lincoln Benefit / Lincoln Life / Living Benefits / Madison Brokerage Corp / Magna Administrative Services / Maple Life Financial / Met Life / Milestone Managers and Providers / Montage Financial Group / National Western Life / Nationwide / New York Life / North American / Old Mutual Financial Network / Pacific Life / Peachtree Life Settlements / Penn Mutual / Phoenix / Presidential Life / Principal Financial / 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 / Strategic Medical Consulting, Inc. (SMC) / Sun Life / Sun Life of NY / Guidon Financial, LLC, LLC / The Ardan Group / The Guardian / Transamerica / United of Omaha / U.S. Financial / US Life / Vespers / ViaSource Funding Group, LLC / West Coast Life / William Penn / Wm. Page & Assoc (Lifeline)

Name of Insured_____ Signature_____

Date of Birth_____ Social Security Number_____ Date _____