

ATTENTION

Aetna and Assurant will prescreen now off of any carrier's applications for Small Group or the attached generic questionnaire. Midwest Security will only prescreen off of their own applications. They will not use the attached generic questionnaire. To save you a step in the process and to get a more accurate prescreen, we recommend that you use the application from the carrier that looks most attractive for the benefits requested. If your prescreen comes back favorable, most of your work is done. If not, we can forward the apps to the other two carriers to see if we get a better result.

Authorization To Release Medical Information For Group Proposal Or Rate Calculation Form

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, employer or plan sponsor, and consumer reporting agencies that have information as to the present or former physical health condition, including drug or alcohol or domestic abuse, and or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnosis, treatment, and prognosis. This authorization is not applicable to psychotherapy notes.

I understand the information obtained by use of this authorization may be used for the solicitation of group proposals or rate calculations from the following insurers or third party administrators: (Please Print Clearly) (This section must be filled out by the agent prior to employee signature.)

_____ Midwest Security Insurance Companies _____

_____ Assurant Health Insurance Company _____

_____ Aetna _____

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 60 days from the signature date below. I understand that I may be request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization.

Employee Signature _____ Date: _____

Spouse Signature _____ Date: _____

Dependent Signature _____ Date: _____

Dependent Signature _____ Date: _____

Agent Signature _____ Date: _____

I have received a copy of this authorization for my records.

Employee Initials _____ Date: _____

EMPLOYEE PRE-QUOTE INFORMATION

This does not constitute an application for insurance. The information requested will enable us to properly evaluate the health insurance needs of your company. All information will be kept confidential.

Company Name: _____

Employee Name: _____

(Circle One): Male or Female Age: Employee _____ Spouse: _____

Coverage Required: Employee Employee/Spouse Employee/Children Family _____ # of Children

Height & Weight: Employee _____ / _____ Spouse _____ / _____

Tobacco Use: Employee Yes No

Spouse Yes No

1. Did you, your spouse, or any covered dependent incur claims in excess of \$2,500 in the past 12 months?
 Yes No

Reason: _____

Current Status: _____

2. Are you, your spouse, or any covered dependent receiving treatment for:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Immune System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Disorder
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis/Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Nervous & Mental including Anxiety or depression
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Back Disorder			
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Track			

If yes, give name, type of treatment administered and medication taken: _____

3. Have you, your spouse, or any covered dependent been advised of a condition that will require medical treatment or surgery in the next 12 months?
 Yes No

If yes, give name, date & details: _____

4. Are you, your spouse, or any covered dependent currently pregnant?
 Yes No

If yes, give name & due date: _____

5. Are you, your spouse, or any covered dependent currently disabled?
 Yes No

If yes, give name & reason: _____

6. Do you, your spouse, or any covered dependent have any other medical condition, past or present, including eating disorders, not listed above?
 Yes No

If yes, please explain: _____

Date: _____ Signed: _____

12/05