BERSON-SOKOL AGENCY, INC.

Informal Inquiry

Please fax, mail or email this form to Berson-Sokol

23500 Mercantile Road Suite C
Cleveland, OH 44122
P: (216) 464-1542
T: (800) 543-6000
F: (216) 464-6522
www.berson-sokol.com

This informal inquiry is used to gather specific information that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any carrier.

Personal History — this section must be completed

Name: ______________________ ☐ Male ☐ Female Social Security # ____________

Address: ______________________ City: ____________ State: _____ Zip: ________

Date of Birth: ____________ Height: ________ Weight: ________ Occupation: ____________

Are you a US Citizen? ☐ Yes ☐ No

Any tobacco or nicotine use (including cigarettes, cigars, pipe, nicotine gum or patch)?

Type: ______________________ Date of last use: ____________

Agent Information — this section must be completed

Name: ______________________ Phone Number: ____________

Address: ______________________ City: ____________ State: _____ Zip: ________

Fax Number: ______________________ Email: ____________

Requested Plan of Insurance — this section must be completed

Type of Insurance: ______________________________

Face Amount: ____________ Premium Amount Desired: ____________ ☐ Annually ☐ Monthly

If you are replacing coverage, will there be any 1035 exchange money with the replacement?

☐ Yes ☐ No If yes, what amount will be carried over? ____________

Please list all inforce and pending coverage:

Company	Policy/Application Date	Amount	Rating Issued	Current Premium	To Be Replaced?

Medical History — this section must be completed

	Date	Illness
1. Please list you primary care physician's name, address and phone number. When did you last consult him/her? Why?		
2. Please list any other physicians consulted in the last five years and the reason why.		

Rev. 09/2012

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Name: ______________________________

Medical History Continued   this section must be completed

3. What hospitals, clinics or other health facilities have you ever been treated?	Date	Illness

4. Please list all current medications and dosages.	Date	Illness

Family History   this section must be completed

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer or diabetes? ☐ Yes ☐ No

If yes, please provide details:

Relationship	Diagnosis	Age at Onset	Age at Death (if deceased)

Drug and Alcohol Usage Questionnaire ☐ check here if this section is not applicable

1. Do you currently drink alcohol? ☐ Yes ☐ No

Date of last consumption: ______________________

Type:	Amount per week:
Beer	
Wine	
Liquor	

2. Did you ever drink substantially more than present? ☐ Yes ☐ No

If yes, when? ______________________

Type:	Amount per week:
Beer	
Wine	
Liquor	

3. Have you ever consulted a doctor or received treatment because of alcohol use? ☐ Yes ☐ No

4. Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No If yes, date: ______________

5a. Have you ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details:

5b. Types of drugs used: ______________________

5c. Date of last use: ______________________

5d. Doctor/Facility name and address: ______________________

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Name: ____________________

Cardiac History ☐ check here if this section is not applicable

1. Date of diagnosis: ____________
2. Number of diseased vessels: ____________
3. Dates, types and results of tests (ekgs, echocardiograms, catheterizations): ____________
4. Dates and details of treatment/surgery (angioplasty, bypass): ____________
5. Date and results of last stress EKG? ____________
6. Cardiologist/Facility address and phone number: ____________

Cancer History ☐ check here if this section is not applicable

1. Date of diagnosis: ____________
2. Exact name and location of cancer: ____________
3. Stage and grade: ____________
4. Dates and details of treatment/surgery: ____________
5. Oncologist/Facility address and phone number: ____________

Diabetes History ☐ check here if this section is not applicable

1. Date of diagnosis: ____________
2. Treatment (list medications and dosages): ____________
3. Do you regularly test your blood glucose? ☐ Yes ☐ No

Frequency: ____________ Last result: ____________

4. Last glycohemoglobin (A1C) test result: ________ mg% Date: ____________
5. Have you ever been diagnosed with having protein and/or microalbumin in your urine? ☐ Yes ☐ No
6. Have you EVER had:

a. eye problems? ☐ Yes ☐ No
b. heart problems? ☐ Yes ☐ No
c. high blood pressure? ☐ Yes ☐ No
d. kidney problems? ☐ Yes ☐ No
e. neuritis/neuropathy? ☐ Yes ☐ No
f. insulin reactions? ☐ Yes ☐ No

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

________________________________ Birthdate ____________ SS# ________________

Patient Name (please print)

Information to be released from: ____

Name of designated facility or provider

____

Address

Information to be sent to: ________________________________

____

______________________ ______________

City, State, Zip Phone

Information to be released:

The most recent five years of pertinent information (Chart notes, labs, x-rays and special test)

Specific information (Please specify):________________________________

Purpose for which disclosure is being made:
Insurance

Patient Authorization:
By executing this Authorization, I authorize all health care providers that have been involved in my care, diagnosis or treatment (including, but not limited to, physicians, hospitals, clinics, medical practitioners, and other medically related facilities) to disclose my medical records (including but not limited to, patient histories, progress notes, test results, x-rays and other diagnostic information) to ExamOne or EMSI for the purpose of determining eligibility for life insurance.

I understand that my records may contain information regarding the diagnosis of treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

I understand and agree that ExamOne or EMSI may disclose my medical records and the information contained in those records to third parties, such as insurance companies, or to the representatives of such third parties (including reinsurers and information agencies) for the purpose(s) stated above.

My Rights:
I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: ____ **DATE:** ____________

(Patient, Guardian*, or Authorized Representative*)

[*Please provide documents to prove authority to sign on behalf of the patient]

This authorization will expire 180 days from the date signed.

Cleveland Clinic **AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

1. Patient Information:

Name (*First, Middle, Last*)		Cleveland Clinic Medical Record #		
Current Address		City	State	Zip
Last 4 Digits Social Security #	Email	Phone Number ( )		Date of Birth / /

2. Release Information From (check all that apply):

- ◻ Cleveland Clinic Ohio facilities **OR** ◻ Specify Cleveland Clinic Ohio facility(ies): ____________
- ◻ Cleveland Clinic Nevada facilities **OR** ◻ Cleveland Clinic Akron Physician Offices (PPG)

NOTE: *For release of medical records from Ashtabula County Medical Center (ACMC), Cleveland Clinic Akron General (CCAG), and Cleveland Clinic Florida, your request must be made directly to ACMC, CCAG or Cleveland Clinic Florida*

3. Release Information To:

Name of Recipient		
Address	**City/State**	**Zip**
Phone Number: ( )	**Fax Number: ( )**	

- ◻ **Release Information To MyChart Account (large requests over 50 pages will be delivered via alternate option selected below)**
- ◻ **Paper**
- ◻ **Secure electronic delivery (provide recipient's email)** ____________

Check delivery option desired

Purpose for Disclosure: ____________
(Purpose for disclosure must be completed prior to processing; e.g. continuing care, personal use, legal)

Dates of Service to Release (FROM): ____________ **(TO):** ____________

◻ Office Visits	◻ History & Physical	◻ Physical/Occupational Therapy Reports
◻ Emergency Department Reports	◻ Cardiac Reports	◻ Homecare Records
◻ Discharge Summary	◻ Laboratory Reports	◻ Radiation Oncology Records
◻ Operative Reports	◻ Radiology Reports	◻ Other

I, the undersigned, authorize Cleveland Clinic to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes as defined below.* Release of Psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

____________ / ____________ __/__/__

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

____

Relationship, if not Patient

**Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient's medical records.*

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative MUST accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*

***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

Submit request to one of the following:

(1) Health Information Management/Medical Record Department,
Health Data Services Ab7
9500 Euclid Avenue, Cleveland, OH 44195

(2) Fax: 1-216-587-8043
Questions? 1-216-444-5580

Mail ☐ Pickup ☐

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1. I authorize Mercy Health, on behalf of HealthSpan Integrated Care and/or HealthSpan Physicians, LLC ("HealthSpan"), to disclose and/or receive for use the following information for the individual named below (Please print):

Patient Name: ______________________ HealthSpan Medical Record #: ____________________

Address: ____

City/State/Zip: ____

Phone #: (_____)_________________________ Date of Birth ____________________

2a. **I AUTHORIZE** *(name of where records coming from)*:

Mercy Health on behalf of HealthSpan
Atten: Health Information Services
3700 Kolbe Road
Lorain, Ohio 44053
Fax # (440)960-4635
e-mail: OHMedcorresp@mercy.com

Phone: (440) 960-3320

2b. **TO RELEASE TO** *(name of where records going to)*:

____
Name of receiving person/organization

____
Street Address

____
City State Zip Code

Phone: (_____)________________________

Email[1]:___________________________

3. At my request the following information may be disclosed and/or used : *(Specify dates where appropriate)*

☐ Immunizations
☐ Medical Record *Date(s):*___________
☐ X-Ray Reports *Date(s):*___________
☐ Other Records *Date(s):*___________
(specify type) ____________________
☐ Laboratory Results *Date(s):*____________
☐ HIV/AIDS Test Results *Date(s):*____________
☐ Mental Health Record *Date(s):*____________
☐ [1]Electronic copy of electronic health record:
(Please provide email address in 2b and complete E-delivery Form)

4. For the purpose of: *(check all that apply)*

☐ Continuity of Care
☐ Form Completion
☐ Eligibility/Enrollment
☐ Personal Use
☐ Attorney Inquiry
☐ Rate Setting
☐ Consultation
☐ Social Security
☐ Employer Request
☐ Insurance Claim
☐ Workers' Comp
☐ Appeals
☐ Other (Specify) ____________________________

Signatures and dates must be on Page 2 for this authorization to be valid.

Revised 1/22/2015

Patient Name: ______________________
HealthSpan Medical Record #: ______________
Date of Birth: ______________________

5. I understand that the information released upon authority of this authorization may include information concerning treatment of physical and mental illness, alcohol/drug abuse, HIV/AIDS test results, diagnoses or treatment of HIV/AIDS, and past medical history information.

6. This authorization will expire one year from the date of signing pursuant to Ohio Revised Code 3701.74(B). I understand that I have a right to revoke this authorization in writing at any time and must submit my written revocation to Mercy Health Attention: Health Information Services, 3700 Kolbe Road, Lorain, Ohio 44053. I understand that the revocation will not apply to any actions taken in reliance on this authorization. Revocation of an authorization used to secure a policy of insurance, including health insurance from a HealthSpan entity, may not be permitted during the period of time the insurer may contest the policy issued or a claim under the policy

7. I understand that Mercy Health and HealthSpan may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on my execution of this authorization, except when HealthSpan seeks authorization (1) because it is providing research-related treatment; (2) for purposes of determining health plan eligibility, enrollment underwriting, or risk rating, so long as the authorization is not for use or disclosure of HIPAA psychotherapy notes; or (3) because it is providing treatment solely for the purpose of creating protected health information for the disclosure to a third party.

8. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and is not protected by the Mercy Health or HealthSpan policy or the HIPAA Privacy Rule.

9. I understand that I (or person authorized to act as my representative) am entitled to receive a copy of this authorization.

By signing this form below, you are authorizing the release of the requested information identified above. If the person signing is not the member/patient indicate the relationship to the member/patient and attach supporting authorization or legal documentation.

______________________________________ ______________
X Signature of Patient or Authorized Personal Representative[1] Date

______________________________________ ______________
Authorized Personal Representative's Name Relationship to Patient

10. I understand that a reasonable fee may be charged for duplication of records and accept full financial responsibility for that fee. Mercy Health may use a contracted service to process this request.

______________________________________ ______________
X Signature of Patient or Authorized Personal Representative[1] Date

______________________________________ ______________
Printed Authorized Personal Representative's Name Relationship to Patient

Signatures and dates must be on Page 2 for this authorization to be valid.

(1) **Authorized Personal Representative** is a person who has legal authority to act for an individual in making decisions related to the individual's health care or for a deceased individual or the deceased's estate. The personal representative can be a person who has been designated by the individual (e.g., Power of Attorney) or otherwise has legal authority (e.g., by operation of law, such as a parent; by court appointment).

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1. PATIENT INFORMATION

LAST NAME	FIRST	MIDDLE	MAIDEN / OTHER NAME(S)	METROHEALTH MEDICAL RECORD #

CURRENT ADDRESS	CITY	STATE	ZIP

DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY #	PHONE #	EMAIL ADDRESS
		( )	

2. REASON NEEDED

PLEASE SPECIFY THE PURPOSE OF YOUR REQUEST:

- ☐ MEDICAL TREATMENT
- ☐ DISABILITY
- ☐ INSURANCE
- ☐ LEGAL
- ☐ PERSONAL
- ☐ OTHER: (please specify) ______________________

3. INFORMATION NEEDED

INFORMATION TO BE DISCLOSED FROM (check as applicable):

- ☐ THE METROHEALTH SYSTEM
- ☐ METROHEALTH RECOVERY RESOURCES
- ☐ SPRY
- ☐ OTHER: (please describe) ______________________

INFORMATION TO BE DISCLOSED (check as many as applicable):

- ☐ Office Visits
- ☐ Emergency Department Reports
- ☐ Test Results (labs, pathology, radiology)
- ☐ Cardiac Reports
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Operative Report
- ☐ Consultations
- ☐ Physical/Occupational Therapy Reports
- ☐ X-Ray Images
- ☐ Substance Abuse Treatment Labs
- ☐ Substance Abuse Progress Notes
- ☐ All Reports Listed
- ☐ Other: (please describe) ______________________

4. ACTIONS TO TAKE

RELEASE INFORMATION TO:

NAME OF RECIPIENT		
ADDRESS	**CITY/STATE**	**ZIP**
PHONE NUMBER ( )	**FAX NUMBER** ( )	

INFORMATION SHOULD BE DELIVERED ON (select one):

- ☐ Release to MyChart
- ☐ Compact Disc (CD)
- ☐ Secure Electronic Delivery (If electronic, provide recipient's email)
- ☐ Fax
- ☐ Mail to the above address
- ☐ Picked-up by: ______________________ (ID is required for pick-up)
- ☐ Paper

I, the undersigned, authorize The MetroHealth System to release health information as indicated above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse.

This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Health Information Management (see contact information below). Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization.

(continued on back)

(continued from front)

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information as per Ohio Revised Code 3701.741. There is no charge to send records directly to my health care provider for continuing care purposes.

If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.

_______________________________ / _______________________________ ______________

*Signature of Patient/Patient's Personal Representative*** *Printed Name* *Date Signed*

____

Relationship, if not Patient

***If other than the patient's signature, a copy of legal paperwork verifying the patient's personal representative **MUST** accompany the request (e.g., court appointed guardian, durable power of attorney for health care). Exception: parent signing for a patient under the age of eighteen.*

***For a deceased patient, a court entry or order appointing a fiduciary, executor, or administrator, or letters of appointment received from Probate Court must accompany an authorization signed by the named individual. If the estate has not been probated, a death certificate is required to be submitted with the documents naming the administrator or executor of the estate.*

****For patients receiving addiction services treatment:** MetroHealth provides this statement with each disclosure made with your consent: "This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client."

Submit completed authorization to one of the following:

1. The MetroHealth System
   Health Information Management Department – G-108
   2500 MetroHealth Dr.
   Cleveland, Ohio 44109

2. Fax: (216) 778-2413

3. Additional Authorization Forms and Ohio fee schedule for medical record copies can be found at: https://www.metrohealth.org/requesting-copies-of-medical-records or call Release of Information (216) 778-4252

University Hospitals

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Records to be released from:

Cleveland Medical Center ☐ Ahuja ☐ Bedford ☐ Conneaut ☐ Elyria ☐ Geneva ☐ Geauga ☐ Parma ☐ Portage ☐ Richmond ☐ UH Home Care ☐ UHPS ☐ Samaritan ☐ St. John ☐

Patient Name ____
(Please Print) Last First M/I

Date of Birth ____________ Social Security Number (last four digits) ____________

Address ______________________________ Phone Number (_____)- ____________
______________________________ Medical Record Number ____________
______________________________ Prior MR # ____________

Treatment Date(s) ____

Please Release Medical Information to the Following Recipient:

Name of Person or Organization ______________________________ Phone # ____________
Address ______________________________ Mailstop ____________
______________________________ Fax # ____________
City State Zip Code

Purpose of Disclosure ☐ at the patient's request

Description of Information to be Released:

☐ Pertinent Summary (includes all * items)

☐ Admission Form
☐ ***Discharge Summary**
☐ ***Emergency Room Report**
☐ ***History & Physical**
☐ ***Consultation Report**
☐ ***Operative Report**
☐ Facesheet / Demographics
☐ Lab Reports
☐ ***Radiology Report**
☐ ***EKG Report**
☐ ***Pathology Report**
☐ ***Card Cath Report**
☐ Physical Therapy
☐ Entire Record
☐ Physician's Notes
☐ Other ______________________________
____
____

I, the undersigned, authorize ______________________________ (Disclosing Institution) and its employees to release Information from my medical records as described above. I understand and acknowledge that the medical record may contain Information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse. I also understand that Information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my Information not being released.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ______________________________ . If I fail to specify an expiration date. event or condition, this authorization will expire in one year.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand there may be charges for the copying and release of Information and accept financial responsibility.

X ______________________________ ____/____/____
Signature of Patient/Legal Representative** Date Signed

______________________________ ☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

☐ By signing this form as the patient's legal representative, I am certifying that there is no court order or other legal reason (such as a binding arbitration decision or final mediation agreement) prohibiting me from obtaining a copy of the requested records.
This box must be checked for ALL releases of records authorized by legal representatives.

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented, the exception is a parent of minors under 18 years of age.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION TO GENERAL AGENT OR BROKER

I,____
Print Name of Proposed Insured

____
Address (Street, City, State, Zip Code)

hereby authorize the insurance companies listed below, their employees, underwriters, officers or affiliates, to disclose any and all medical information to the Broker General Agent, The Berson-Sokol Agency, which information has been collected in connection to my application for insurance dated____________, and submitted through the Berson-Sokol Agency. This information includes, but is not limited to the results of any physical examinations or tests, electrocardiogram, chest x-ray, and Attending Physician Statements. This information also includes but is not limited to information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco.

The purpose of this authorization is to facilitate submission of this information to the Broker General Agent to other insurers to evaluate an application on my life. The companies listed below assume no liability with respect to any application for life or long-term care insurance to other companies, and makes no representation as to the completeness or accuracy of the information. I also understand it is my responsibility to disclose any and all requested medical information to any insurance carrier to which I apply for insurance coverage.

I further understand that the privacy policies of those companies listed below does not extend to the copy of the information provided to The Berson-Sokol Agency, (the Broker General Agent) and/or the Broker.

This authorization is effective as of the date it is signed, and shall continue for six (6) months unless otherwise provided by law. I understand I may revoke this authorization by providing written notification to the insurance company holding my life insurance application, which revocation shall be subject to the rights of the insurance company to the extent the insurance company has acted in reliance on the notification prior to notice of revocation.

A copy of this authorization shall be as valid as the original.

I acknowledge that I have received a copy of this authorization from The Berson-Sokol Agency and/or its representatives.

______________________________________ ______________
Signature of Proposed Insured Date

Insurance Companies covered by this agreement:

American General
American National
Assurity
Banner Life/Legal & General
CSAC/Farm Bureau
Fidelity Life
Forethought/ForeCare
Gerber
Global Atlantic/Forethought
Guardian
John Hancock
Kemper
LifeSecure
Lincoln Life Brokerage
Lincoln Financial Group
MedAmerica
MetLife/Brighthouse
Minnesota Life
Motorists/Encova
Mutual of Omaha LTC
North American(NACOLAH)
Pacific Life
Protective Life
Presidential
Prudential
SBLI of MA
State Life/One America
The Marketing Alliance
Transamerica
United Home Life
United of Omaha
United Security Assurance
VOYA/ING
Welcome Funds, Inc.
William Penn (NY)

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