

**Please complete and mail this application to:**  
**The Bryton Companies, 1466 28<sup>th</sup> Street, Suite 100, West Des Moines, IA 50266-1430**  
**PH: 515 223-1601 TOLL FREE: 800.288.9522 FAX: 515.223.9301 EMAIL: info@bryton.com**

**Confidential Personal and Insurance Information**

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After receiving the following three pages of information, The Bryton Companies will be able to evaluate the opportunity to present you with an offer to purchase your life insurance policy. Please complete the following forms and sign pages two and three.

**Medical, financial or other personal information that you provide will not be disclosed to any other person or entity without your specific written consent.**

**1. Personal Data**

Name of Insured \_\_\_\_\_ Social Security # \_\_\_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number(s): Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex Male Female

Dependent Children: Yes No

Are you currently employed? Yes No If No, date last worked \_\_\_\_\_

**If policy owner is different than above**

Name of policy owner \_\_\_\_\_ Social Security # \_\_\_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number(s) Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

**2. Life Insurance policy Information**

**Please enclose a copy of the policy and/or please complete the following:**

Name of Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Date Policy was issued \_\_\_\_\_ Coverage/Face Amount \_\_\_\_\_

Amount of Premium: \$ \_\_\_\_\_ How frequently is premium paid? \_\_\_\_\_

Type of policy: Term Whole Life Universal Life Other \_\_\_\_\_

Is this a group or individual policy? Individual Group Converted Group

**If group policy, please provide the following information:**

Page 2 of 3

Name of Organization Providing Coverage\_\_\_\_\_

Name of Benefits Manager or Third Party Administrator\_\_\_\_\_

Telephone Number ( )\_\_\_\_\_

May we contact the person named above?                      Yes                      No

**3. Medical History**

Please give a brief description of your medical condition:

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**Name of Physician seen for this medical condition:**

Name of Physician\_\_\_\_\_

Address\_\_\_\_\_Telephone ( )\_\_\_\_\_

City\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_

**Who is your primary or family physician? (if different than above)**

Name of Physician\_\_\_\_\_

Address\_\_\_\_\_State\_\_\_\_\_Zip\_\_\_\_\_

If there are any other physicians that have treated you in the last three years, you may attach an additional page including their full name, address and telephone number.

\_\_\_\_\_  
Signature of Policy Owner

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

### Authorization for the Release of Information

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide the bearer and/or its authorized representatives, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the insured.

This authorization allows for the disclosure inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms and amendments concerning the policy. I understand that funding sources will only use information pursuant to this Authorization. These funding sourced will not release any information to any person or organization except as may be otherwise lawfully required or as I may further authorize. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

_____ Signature of Insured	_____ Signature of Policy Owner	_____ Date
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_____ Printed Name	_____ Printed Name	_____ Date
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_____ Signature of Witness	_____ Signature of Witness	_____ Date
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_____ Printed Name	_____ Printed Name	_____ Date
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