The Penn Insurance and Annuity Company of New York
Administrative Office Mailing Address:
PO Box 390 Millville NJ 08332-0390
P: 1-855-436-0952

Request for Rate Reduction

Home Office Use Only

❒ APP ❒ DEC ❒ W/D ❒ PP	UND	Date

General Information

Medical #:_____ Policy #: _____ Agency:_____

Name of Insured: _____ Address: _____

_____

Date of Birth:_____ Occupation:_____ Height: _____ Weight:_____

Do you currently use any tobacco products? ❒ Yes ❒ No

Have you smoked any cigarettes or used any tobacco products in the past and quit? ❒ Yes ❒ No

If "Yes", When did you quit? _____
Month /Day/ Year

Did you quit at the recommendation of a physician because of a medical condition? ❒ Yes ❒ No

If "Yes", give the medical condition, etc._____

For policies rate due to occupation, a letter of explanation from the applicant must accompany this form.
For policies rated due to aviation or avocation, the appropriate questionnaire must accompany this form.

Medical Information

Answer the following questions "Yes or No":

Since making application for the above-numbered policy, to the best of your knowledge and belief, have you had, been told that you had, been treated for or had surgery for:

(Please circle any condition answered "Yes" and give details in the space to the right. Include name, address and phone for physicians, hospitals, etc.)

a. Heart, blood vessels, chest pain, palpitation, heart murmur, heart attack, shortness of breath, high blood pressure? ❒ Yes ❒ No _____

b. Lungs, tuberculosis, asthma, bronchitis or emphysema? ❒ Yes ❒ No _____

c. Albumin, blood or sugar in urine, diabetes, kidney or reproductive organs? ❒ Yes ❒ No _____

d. Mental, emotional or nervous system disorder, epilepsy, stroke or any disorder of the brain? ❒ Yes ❒ No _____

e. Anemia or blood disorder? ❒ Yes ❒ No _____

f. Cancer or other tumor? ❒ Yes ❒ No _____

g. Thyroid, gout, arthritis, muscles, bones or joints? ❒ Yes ❒ No _____

h. Ulcers, rectal bleeding or digestive system (stomach, intestines, liver, gall bladder or pancreas)? ❒ Yes ❒ No _____

i. Any physical deformity or surgical operation? ❒ Yes ❒ No _____

j. Alcoholism, alcohol abuse or addiction? ❒ Yes ❒ No _____

k. Ever used heroin, narcotics, cocaine or any drugs except as prescribed by a physician? ❒ Yes ❒ No _____

l. AIDS or AIDS related conditions? ❒ Yes ❒ No _____

m.Are you now under observation or taking treatment? ❒ Yes ❒ No _____

NAME AND ADDRESS OF PHYSICIAN	DATE LAST SEEN	REASON AND TREATMENT GIVEN

♦ Authorization to Release Information

I authorize the following persons and/or institutions that have any records or knowledge of me or my minor children, my employment, and my or my minor child's health to give any such information to The Penn Insurance and Annuity Company of New York (PIA of NY) or its reinsurers: any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person. I understand that the information released to PIA of NY or its reinsurers will be used to determine my eligibility for the insurance requested. PIA of NY may re-disclose such information for that purpose to any reinsurer, and to any person or entity performing a business or legal function for the benefit of PIA of NY. This information may also be re-disclosed as otherwise specifically permitted or required by law. This authorization extends to and includes any infor-mation relating to alcohol or drug abuse, tobacco use history or mental health care. This authorization or photo copies of it will be valid for two and one half years following the date signed, unless otherwise required by law. The information released to PIA of NY will not be given, sold or transferred to any other person not mentioned above.

I acknowledge that I have read the IMPORTANT NOTICE and I understand that I am entitled to a photocopy of this authorization upon request. I hereby acknowledge receipt of the notice to applicant.

X _____ _____

Legal Signature of Insured Date

The Penn Insurance and Annuity Company of New York
Administrative Office Mailing Address:
PO Box 390 Millville NJ 08332-0390
P: 1-866-826-8471

Request for Rate Reduction
Important Notice to Applicant

Medical Information Bureau: Information you provide will be treated as confidential except that The Penn Insurance and Annuity Company of New York (PIA of NY) may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. PIA of NY or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accor-dance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office: Post Office Box 105, Essex Station, Boston, MA 02112; telephone: 617-426-3660.

Fair Credit Reporting Act: As part of our normal procedure, an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members, business associates, friends, financial sources, neighbors or others with whom you are acquainted. Such an inquiry typically may include information as to character, general reputation, personal characteristics and mode of living of the person to be insured. You have the right under the law to receive on your written request, disclosures of the nature and scope of any investigative consumer report.

Supplementary Notice of Information Practices: PIA of NY may need to obtain data about you prior to issuance of insurance. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent. You have the right of access and correction to data to data received about you, but data about a civil or criminal proceeding is excepted. If you would like a more detailed explanation of our information practices, please contact: Underwriting Department, The Penn Insurance and Annuity Company of New York, PO Box 390 Millville NJ 08332-0390.

Client Copy

Penn Insurance and Annuity of New York

AUTHORIZATION TO OBTAIN AND DISCLOSE PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF DETERMINING ELIGIBILITY FOR INSURANCE

Name of Insured: _____Date of Birth:_____

Address:_____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to The Penn Insurance and Annuity Company of New York. 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 my signature below, I acknowledge that any agreements I have made to restrict my protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that PIA of NY may:

1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with PIA of NY.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written request for revocation to the administrative offices of The Penn Insurance and Annuity Company of New York PO Box 390, Millville NJ 08332-0390 Attention: Underwriting Department. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or the extent that The Penn Insurance and Annuity Company of New York has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, The Penn Insurance and Annuity Company of New York may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative or I have received a copy of this authorization.

_____

Signature of Individual Whose Information is to be Disclosed or Authorized Representative

_____ _____

Print Name of Individual or Authorized Representative Date Signed

COMPLETE IN DUPLICATE AND RETAIN A COPY FOR YOUR RECORDS