CPS INSURANCE SERVICES

INFORMAL INQUIRY

Agent:

Name: _____

Phone: _____

SS/Tax ID #: _____ Email: _____

Address: _____

_____

Client:

Name: _____

D.O.B.: _____ Place of Birth: _____

Social Security #: _____

Resident Address: _____

_____

Sex: [ ] Male [ ] Female Height ___ ft. ___ in. Weight _____ lbs.

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Beneficiary Name and Relationship: _____

Plan of Insurance / Amount Desired: _____

How much life insurance in force now?: _____

Is this new insurance intended to replace existing coverage? _____

Have you ever used any form of tobacco? [ ] Yes [ ] No

If yes, give form and frequency: _____

Has use been discontinued? [ ] Yes [ ] No

If yes, please detail and give reason: _____

_____

Why are you applying on an informal basis? _____

_____

Has case been submitted to other companies in the past 6 months? [ ] Yes [ ] No

If yes, list companies, file numbers, dates submitted and offers made: _____

_____

_____

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:_____

Name of Company:_____
Amount: _____ Year:_____ Issued?: ___Std. Premium: ___ Extra Premium: _____
Reason Rated or Declined:_____

Name of Company:_____
Amount: _____ Year:_____ Issued?: ___Std. Premium: ___ Extra Premium: _____
Reason Rated or Declined:_____

What physician did you last consult, other than insurance exam?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

What physician have you consulted in the past 10 years?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

What physician have you consulted in the past 10 years?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

What physician have you consulted in the past 10 years?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

What physician have you consulted in the past 10 years?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

In what hospitals, clinics, etc. have you ever been treated?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

In what hospitals, clinics, etc. have you ever been treated?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

In what hospitals, clinics, etc. have you ever been treated?
Name: _____ Date: _____
Address: _____
_____
Reason: _____

Who is your personal physician?
Name: _____ Date: _____
Address: _____
_____

Date of first consultation?: _____

..... *** IMPORTANT *** IMPORTANT *** IMPORTANT *** .....

AGENT: PLEASE MAKE SURE THE PROPOSED INSURED SIGNS THE AUTHORIZATION SECTION OF THIS DOCUMENT.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization:
(1) Authorization: Authorization to Obtain and Disclose Information
(2) Insurance Support Organizations: Consumer Reporting Agency.

I understand that the life insurance companies named below, their reinsurer, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage. Therefore, I authorize any: (1) person licensed to provide health care service (2) hospital (3) clinic or medical facility (4) insurer (5) reinsurer (6) insurance support organization (7) financial source and (8) employer, to give the types of information listed below when this authorization is presented. A copy of this Authorization is as valid as the original. I authorize all said sources to give such records or knowledge to CPS Insurance Services. The protected health information is to be disclosed under the Authorization at my request, as permitted by 164.508©(1) (iv) of the Health Insurance Probability and Accountability Act (HIPAA) Privacy Rule.

The types of information will include facts about my: (1) mental and physical health (2) other insurance coverage (3) hazardous activities (4) character (5) general reputation (6) mode of living (7) finances (8) vocation and (9) other personal traits. The life insurance companies named below and their reinsurer will use the information in order to determine whether I am insurable. The insurance agent may also use this information to help update and improve my insurance program. Those parties named in the first paragraph of this Authorization, excluding insurance support organizations, may disclose the information they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply (2) reinsurer or (3) other persons who perform business, professional, or insurance tasks for them. Insurance support organizations may disclose information according to any contract with a member company or organization. Information may also be disclosed as allowed by law.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION (cont.)

Duration: This authorization is effective as of the date signed below and will remain in effect for two years unless revoked sooner.

Revocation: This authorization is subject to written revocation by its signer at any time. The written revocation will be effective upon receipt by the Disclosing Party, except to the extent the Disclosing Party or others have acted in reliance upon this authorization prior to receipt of the revocation.

Re-disclosure: I understand that once health information I have authorized to be disclosed reaches the party(ies) indicated, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

I understand that I, or my authorized representatives, may request to receive a copy of this Authorization. _____ (initials)

I acknowledge receipt of the Notice to Proposed Insured - Parts I and II. _____ (initials)

Signed at _____ this _____ day of _____, 20 ____.

Proposed Insured Signature: _____

Witness or Other Authorized Person Signature:_____

AIG-American General / Allianz / American National / Aviva / AXA Equitable / Banner Life / Companion / Genworth Companies / Hartford / ING Companies / John Hancock / Lincoln Benefit / Lincoln Life / Met Life Investors / New York Life / Nationwide / North American / PHL Variable/Phoenix / Principal Financial / Protective / Prudential / Savings Bank Life / Sun Life / Transamerica / United of Omaha / West Coast Life / Western Reserve / William Penn

AGENT INSTRUCTIONS: THE NOTICE TO PROPOSED INSURED (INCLUDING FCRA NOTIFICATION) APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

NOTICE TO PROPOSED INSURED - PART I
(Must be given to the proposed insured before or at the time of signature)

Notice of Insurance Information Practices - In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely primarily on information provided by you. The companies may also see information from others, such as medical professionals who have treated you. In some cases, they may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. You have the right to request to be interviewed in connection with that report. You may receive a copy of the report by contacting the Consumer Reporting agency as explained in the Federal Fair Credit Reporting Act Notice. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in the insurance companies' files, including information contained in investigative consumer reports. You also have the right to see correction of information you believe to be inaccurate.

NOTICE TO PROPOSED INSURED - PART II
Federal Fair Credit Reporting Act Notice (FCRA)
In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial resources, or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics, and mode of living. Upon written request to the life insurance companies listed in this Notice within a reasonable time after receipt of this Notice, you will be informed whether or not an investigative consumer report was requested and, if so, you will be advised of the name and address and phone number of the consumer reporting agency to whom to the request was made. The Consumer Reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect and receive a copy of any such reporting by contacting the Consumer Reporting agency.

The above is a general description of the listed insurance companies and your agent's information practices. If you would like to receive a more detailed explanation of those practices, please send your request to CPS Insurance Services at 18551 Von Karman Ave., Suite 150, Irvine, CA 92612.