CPS INSURANCE SERVICES

INFORMAL INQUIRY

Agent's Name_____ Agent's Phone_____ / Fax _____			
Agent's SS# / Tax I.D._____ Agent's Address _____			
Client's Name(s)	D.O.B.	Place of Birth	Soc. Sec. #
Resident Address		Beneficiary (Name and Relationship)	
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Sex ☐ Male ☐ Female	Height_____ft.____in.	Weight_____lbs.
Marital Status Married Single Divorced Widowed	Sex Male Female	Height ft. in.	Weight lbs.
Plan of Insurance / Amount Desired:	Amount of life insurance in force now?	Is this new life insurance intended to replace existing coverage? Yes No	
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 date and give reason: _____		
Why are you applying on an informal basis?			
Has case been submitted to other companies in 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 and Address	Phone	Date Seen	Reason
What physician did you last consult, other than insurance exam?				
What physician have you consulted in the past 10 years?				
In what hospitals, clinics, etc. have you ever been treated?				
Who is your personal physician?				
Date of first consultation?				

FAMILY HISTORY:

Have Any of Your Family Members Been Diagnosed With:	Cancer: ☐ Yes ☐ No	Diabetes: ☐ Yes ☐ No	Heart Disease or a CVA (Stroke): ☐ Yes ☐ No	
If Yes, Provide Illness and Age of Onset:	Father:	Mother:	Sibling 1:	Sibling 2:
If Deceased, Provide Age & Cause of Death:	Father:	Mother:	Sibling 1:	Sibling 2:

FINANCIAL INFORMATION:

Personal Earned Income:	$	Spouse Earned Income:	$
Personal Unearned Income:	$	Spouse Unearned Income:	$
Source of Unearned Income:		Source of Unearned Income:	
Estimated Net Worth:	$	Estimated Liquid Net Worth:	$

EXERCISE:

Do you participate in a regular exercise routine? If so, please indicate the type of activity, such as walking, running, cycling, swimming, aerobics, strength training, sports, or yoga.		
Activity	**Frequency**	**Time per Session**
	Times per **Day Week Month Year**	**Hours Minutes**

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GENERAL INFORMATION:

Please answer the following questions:		
Have you ever used any product containing tobacco or nicotine?	Yes	No
In the past 24 months, have you applied for any other life insurance?	Yes	No
Have you ever been declined, postponed, or charged an additional premium for life, health, long-term care, or disability insurance?	Yes	No
In the last 5 years, have you received any disability, chronic illness, long-term care, or accident-related medical benefits, or are you currently eligible to do so?	Yes	No
Are you now a member, or have you entered into a written agreement to become a member of the U.S. Armed Forces, National Guard, or Reserves?	Yes	No
In the past 5 years have you had any moving violations?	Yes	No
In the past 5 years have you had your license suspended or revoked or plead guilty to or been convicted of reckless driving or driving under the influence of alcohol or drugs (DUI or DWI)?	Yes	No
Have you ever pleaded guilty to or been convicted of any infraction, misdemeanor, or felony, or do you currently have any criminal charges against you?	Yes	No
Have you had any bankruptcies in the past 7 years, do you intend to declare bankruptcy in the next 2 years, or do you have any suits, judgments, or liens pending against you at this time?	Yes	No

HEALTH AND LIFESTYLE INFORMATION:

Please answer the following questions:		
In the next 2 years, do you intend to travel or reside outside of the U.S. or Canada?	Yes	No
In the last 2 years, have you flown as a pilot, copilot, or crew member, or do you intend to do so within the next 2 years?	Yes	No
In the last 2 years have you participated in rock or mountain climbing, racing of any motor-powered land vehicle or watercraft, scuba diving, mixed martial arts, or aeronautics (including hang gliding, sky diving, base jumping, parachuting, ultralight, soaring, and ballooning) or do you intend to do so within the next 2 years?	Yes	No
In the past 1O years have you consumed marijuana in any form?	Yes	No
Excluding marijuana, have you ever used narcotics, amphetamines, cocaine, heroin, or any other drugs, except as prescribed by a licensed member of the medical profession?	Yes	No
Have you ever received medical treatment, counseling, or participated in a support group for the use of alcohol or drugs, or been advised to limit or discontinue use by a licensed member of the medical profession?	Yes	No
Do you participate in a regular exercise routine? If so, please indicate the type of activity, such as walking, running, cycling, swimming, aerobics, strength training, sports, or yoga.	Yes	No
In the past 1O years have you been diagnosed, treated, been given medical advice, or received follow up by a licensed member of the medical profession for any of the following conditions:		
High blood pressure and/or high cholesterol?	Yes	No
Coronary artery disease, heart attack, cardiac arrest, congestive heart failure, or atrial fibrillation?	Yes	No
Any disorder, disease, or defect of the heart, arteries, or veins, including chest pain, heart murmur, blood clots, congenital defect, peripheral vascular disease, irregular heart rate or rhythm, or aneurysm?	Yes	No
Any disorder or disease of the blood, including anemia, bleeding or clotting disorder, thrombosis, or embolism?	Yes	No
Cancer of any type or any disorder or disease of the lymphatic system including, leukemia, lymphoma, skin cancer, cyst, tumor, or polyp of any kind, malignant or benign?	Yes	No
Any disorder or disease of the urinary system or kidneys including, kidney stones, polycystic kidney disease, or any findings of blood, sugar, or protein in the urine?	Yes	No
Any disorder or disease of the endocrine or glandular system, including diabetes, glucose intolerance, high blood sugar, hypothyroidism, or other thyroid disorder?	Yes	No
Any disorder or disease of the liver, gallbladder, bile ducts, or pancreas, including pancreatitis, hepatitis, cirrhosis, or gall stones?	Yes	No
Any disorder or disease of the digestive system, including acid reflux, ulcers, appendicitis, Crohn's, colitis, Celiac, Barrett's esophagus, gastrointestinal bleeding or blood in the stool?	Yes	No
Any disorder or disease of the lungs or respiratory system, including shortness of breath, asthma, sleep apnea, sarcoidosis, COPD, or emphysema?	Yes	No
Any disorder or disease related to your behavioral, emotional, or mental health, including depression, anxiety, bipolar disorder, insomnia, or any other psychological or psychiatric disorder?	Yes	No
Any disorder or disease of the brain, nervous or muscular systems, including migraines, seizures, fainting, stroke, TIA (transient ischemic attack), paralysis, multiple sclerosis, Parkinson's disease, or any cognitive impairment?	Yes	No
Any disorder or disease of the bones, joints, back, neck, or connective tissue, including arthritis of any type, amputation, gout, fibromyalgia, chronic pain, osteoporosis, or other rheumatic disorder?	Yes	No
Other than as previously disclosed, any immune or auto-immune disorder or disease, excluding those related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)?	Yes	No
Any disorder, disease, or abnormal test results of the breast, ovaries, uterus, prostate, testes, or reproductive system?	Yes	No
To the best of your knowledge, are you currently pregnant, were you pregnant in the last 24 months, or have you ever experienced complications related to a pregnancy?	Yes	No
Any disorder or disease of the eyes, ears, nose, throat, mouth, skin, hair, or nails?	Yes	No
In the last 5 years have you undergone any diagnostic tests, excluding those related to HIV or AIDS? (e.g. blood, urine, EKG, biopsy, x-ray or other imaging study, or other screening tests)	Yes	No
In the last 5 years have you been advised to have any consultation, surgery, treatment, biopsy, confinement to a medical facility, or diagnostic test (excluding those related to HIV) that has not yet been completed or are you awaiting results?	Yes	No
In the last 5 years, have you been treated, consulted, or given medical advice by any healthcare professional or facility for any disorder, disease, symptoms, injury, or allergies not previously mentioned?	Yes	No
Have you ever been diagnosed or treated by a licensed member of the medical profession or tested positive for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No

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Please use the space below for details to any "Yes" responses:

Agile / American General / Allianz / Assurity / Banner Life / Coventry / Equitable / Global Atlantic / Illinois Mutual / John Hancock / Lincoln Life / Magna / MassMutual / National Life / New York Life / North American / Pacific Life / Penn Mutual / Petersen International / Principal Life / Principal National Life / Protective / Prudential / Securian / The Standard / Symetra / Transamerica / United of Omaha / William Penn / Zurich Life

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AGENT: PLEASE MAKE SURE THE PROPOSED INSURED REVIEWS, COMPLETES, SIGNS AND IS SUPPLIED WITH A COPY OF THIS DOCUMENT

NOTICE TO PROPOSED INSURED - PART I

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.

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.

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.

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

I acknowledge receipt of a copy of this document, including the Notice to Proposed Insured - Parts I and II._____(initial)

Signed at:_____this_____day of_____, 20 ____

Proposed Insured Signature: _____

Witness or Other Authorized Person Signature: _____

Agile / American General / Allianz / Assurity / Banner Life / Coventry / Equitable / Global Atlantic / Illinois Mutual / John Hancock / Lincoln Life / Magna / MassMutual / National Life / New York Life / North American / Pacific Life / Penn Mutual / Petersen International / Principal Life / Principal National Life / Protective / Prudential / Securian / The Standard / Symetra / Transamerica / United of Omaha / William Penn / Zurich Life

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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 4400 MACARTHUR BLVD. 8TH FLOOR. NEWPORT BEACH, CA 92660.