Capitas Preliminary Inquiry

This is NOT an application for life insurance. It is a preliminary evaluation to assist in determining insurability only.

Client Information

Name of Insured: ____ Soc Sec #: ______ - ______ - ______ Date of Birth:____ /_______ /_______

Address: ____ City: ___________________________ State:___________ Zip: ____________

Preferred Phone Number for Exam Scheduling: ________________________ Gender: ☐ Male ☐ Female

Height: ____ft._____in. Weight:_______lbs Tobacco Use: ☐ Yes ☐ No If yes, type: _________________ Date last used:__________

Occupation: _____________________ Employer: ______________________ Annual Income: $ ________________ Net Worth: $ ____________

Are you a US Resident? ☐ Yes ☐ No Are you a US Citizen? ☐ Yes ☐ No If either is No, what country? ______________________

How many days in US? Please include copy of Passport________________________ Type of Visa__________ Exp. Date :____ /_______/_______

Do you own US Domiciles Assets? ☐ Yes ☐ No Do you own Non-US Domiciles Assets? ☐ Yes ☐ No

	Verifiable Assets	Verifiable Liabilities	Net Worth
Non-US			
US			

Foreign Travel Details: List all travel planned outside the US/Canada (Country/City/Duration/Frequency per year and Purpose)

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Coverage Information

Face Amount $_________________ Policy Type: ☐ Indiv ☐ Surv ☐ UL ☐ GUL ☐ WL ☐ VUL

Proposed Premium: $ ___________________ ☐ Single Pay ☐ Term Years level: ____ ☐ ROP State of Issue: ____________________

Total insurance in-force now: $ ___________________ Date last purchased:_____/_____/_____ Rated? ☐ Yes ☐ No

Will new insurance replace any in-force insurance? ☐ Yes ☐ No

Will this be a 1035 Exchange? ☐ Yes ☐ No If Yes, approximate exchange: $ _____________________________

Have you ever been declined or rated for insurance? ☐ Yes ☐ No If Yes, please provide details: _____________________________

Medical Provider Information

Name of Primary Care Physician: ____________________________ Date Last Consulted: ______ /_______ /_______ Reason: _________________

Full Address:_____________________________________ City: ________________State: ____ Zip:________ Phone: (___) ____ - ______

Current diagnosis and medications: ____

Name of Specialist:_______________________________________Date Last Consulted:_______/_______ /_______ Reason: _________________

Full Address:_____________________________________ City: ________________State: ____ Zip:________ Phone: (___) ____ - ______

General Questions (please check any items or activities from the list below that apply and provide details):

A. ☐ Cardiovascular ☐ Heart ☐ Angina ☐ Stroke ☐ HBP
B. ☐ Cancer ☐ Location ____________________
C. ☐ Diabetes ☐ Type 1 ☐ Type 2 Age at dx: _____
D. ☐ Any other medical conditions including:
☐ mental/nervous ☐ respiratory ☐ urinary ☐ gastrointestinal
E. ☐ Drug Abuse ☐ Alcohol Abuse
F. ☐ Personal bankruptcy
G. ☐ Driving record ☐ DWI/DUI ☐ violations
H. ☐ Private aviation
I. ☐ Hazardous avocations:___________________________
J. ☐ Travel or residence outside the US or Canada
K. ☐ Other

Details (A-K)

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Agent/Financial Advisor To Complete This Section

Agent/Advisor Name: __________________________________ SSN:_____ - _____- ______ Email: __________________________________

Firm: ____ Branch City: ______________________________ Business Phone (_____) _____ - ______

Licensed in: Residence state of insured: ☐ Yes ☐ No Owner State: ☐ Yes ☐ No Trust State: ☐ Yes ☐ No

SVP Name:____ CTP: ____

AUTHORIZATION FOR RELEASE OF HEALTH RELATED-INFORMATION

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Name of Proposed Insured/Patient (First, Middle, Last)

____/____/______ _______-______-_________

Date of Birth **Social Security Number**

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit managers, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to CAPITAS FINANCIAL, INC./Pacific Southwest Financial and its affiliates, agents, employees and representatives *(referred to collectively as* CAPITAS FINANCIAL *going forward*). This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information to be released may include, but not be limited to, the following: alcohol or drug abuse treatment, psychiatric treatment (but not psychotherapy notes), pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

By signing below, I amend my agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction to CAPITAS FINANCIAL.

My protected health information is to be disclosed under this Authorization so that CAPITAS FINANCIAL may disclose this information to the insurance companies below for the following purposes: 1) underwrite my application for coverage by making eligibility, risk rating, policy certificate issuance and enrollment determinations; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with an insurance company. I understand that CAPITAS FINANCIAL may release and disclose my medical records obtained under this authorization to the Life Insurance Representative(s) and its staff, affiliated companies, and/or entities, insurance companies and their re-insurers for the purposes as described in this paragraph. CAPITAS FINANCIAL does not make insurance approval decisions regarding this protected health information.

Insurance Companies/Vendors we may share the information with:

Accordia Life & Annuity Co.
Asset Life Settlements
Allianz Life Ins. Co. of NA (Annuities)
American General Life
American National
American National Life of NY
Americo Financial Life & Annuity Ins. Co.
Ameritas Life Ins. Corp.
Assurity Life Ins. Co.
Athene Annuity & Life Assurance Co. of NY
Athene Annuity and Life Co.
AVIVA/Indianapolis Life
AVS
AXA
AXA Equitable Life Ins. Co.
Banner Life Ins. Co.
Brighthouse Life Ins. Co.
Brighthouse Life Ins. Co. of NY
Canada Life Assurance Company
Capitas Financial, Inc.
Columbus Life
Companion Life Ins. Co.
Coventry
Credit Suisse
Delaware Life
Fasano
First Symetra National Life Ins. Co. of NY
Foresters
Forethought Life Ins. Co.
Genworth Financial
Genworth Life & Annuity Ins. Co.
Genworth Life Ins. Co. of NY
Genworth Life Ins. Co. of NY/LTC
Genworth Life Ins. Co./LTC
Gerber Life Ins. Co.
Global Atlantic
Great America Life Ins. Co.
Guardian Life Ins. Co. of America
Habersham Funding, LLC
Hartford Life
Integrity Life
IMS
ING
Jet Stream
John Hancock
John Hancock of NY
Legal & General
Life Ins. Co. of the Southwest/National Life Ins. Co.
LifeSecure Ins. Co.
Lincoln Financial
Lincoln Life Ins. & Annuity Co. of NY
Lincoln National Life Ins. Co.
LTC Global
Maple Life
Mass Mutual
MetLife
Minnesota Life
Minnesota Life Ins. Co.
MIR Associates, Inc.
MONY
Mutual of Omaha
Mutual of Omaha/DI
National Guardian Life Ins. Co.
Nationwide Life Ins. Co.
New York Life
North America
North American Co for Life & Health
One America
Pacific Bridge Insurance Services, Inc.
Pacific Life
Penn Mutual
Phoenix Home Life
Principal Life Ins. Co.
Principal Life Insurance Company
Principal Life/DI
Principal National Life Ins. Co.
Principal National Life Insurance Company
Progressive Capital
Proscan Partners
Protective Life
Protective Life & Annuity Ins. Co.
Prudential
Prudential Life Ins. Co.
Q Capital Strategies
ReliaStar Life Ins. Co.
ReliaStar Life Ins. Co. of NY
Securian Life Inc. Co.
Security Life of Denver
Security Mutual Life Ins. Co. of NY
Settlement Masters, LLC
State Life Ins. Co/One America
Sun Life Assurance Company of Canada
Symetra
Symetra Life Ins. Co.
Tellus Brokerage Connections
The Standard
Transamerica
Transamerica Financial Life Ins. Co.
Transamerica Life Ins. Co.
Transamerica Life Ins. Co./LTC
Transamerica Occidental Life Ins. Co.
United of Omaha Life Ins. Co.
United States Life Ins. Co. in the City of NY
United World Life and Omaha Insurance Co.
Update Legal
Valley Forge Life Insurance Company
Voya Financial
Voya Insurance & Annuity Co.
Welcome Funds
William Penn Life Ins. Co. of NY
West Coast Life
Westside Copymaster
Zurich Life
21st Services
Other:_____________________

This Authorization will remain in effect a maximum of twenty-four (24) months following the date of my signature below and a copy of this Authorization is as valid as the original. I understand I have the right to revoke this Authorization in writing at any time, by sending a written request of revocation to: CAPITAS FINANCIAL, but that my revocation will not be effective until it is received by My Providers. I understand that this revocation is not effective to the extent any of my providers has relied on the authorization or an insurance company has or may use the prior authorized information in connection with any insurance policy. 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 if I refuse to sign this Authorization, My Providers may not (a) refuse to provide me treatment and/or (b) refuse to accept payment from me for health care services. I understand that if I refuse to sign this Authorization, the insurance company 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 I am entitled to receive, upon request, a copy of this authorization.

AUTHORIZATION FOR USE AND DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION (NPI)

I, the Policy Owner/Proposed Policy Owner, authorize Capitas Financial, Inc. or any affiliated company (hereinafter collectively “Capitas”) to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient, as such terms are defined below. This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Capitas and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or; (2) market Insurance Products and Services to me.

I, the Insured/Proposed Insured (if different than the Policy Owner/Proposed Policy Owner), authorize Capitas to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient (as such terms are defined below). This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Capitas and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

“Nonpublic Personal Information” means information, including, without limitation, nonpublic personal, financial, health and medical information about the Policy Owner and Insured (if different than the Policy Owner) and the Policy Owner/Insured’s identity as an owner/insured under a Life Insurance Policy that is obtained, whether from the Policy Owner/Insured, any of the Policy Owner’s/Insured’s agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

“Authorized Recipient” includes any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described.

“Insurance Products and Services” means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also include long term care or other types of health insurance.

The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each agree and consent that this authorization shall be effective from the date hereof until the earlier of (a) the date that is two (2) years after the date hereof, or (b) an earlier date as may be required by applicable law or regulation. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) have the right to revoke this authorization, at any time, by providing written notification to Capitas.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each certify that he or she is executing and delivering this authorization freely and voluntarily as of the date written below. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) further certify that the authorization is written in plain language and acknowledge that each has received and retained a copy of this signed authorization for future reference.

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Signature of Proposed Insured/Patient or Personal Representative **Date**

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Description of Personal Representative’s Authority or Relationship to Proposed Insured Patient