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: _____

Home Phone: _____ Work Phone: _____ 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? _____

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): _____

_____

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

_____ _____/____/_____

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

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, 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/RUSHING FINANCIAL GROUP 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.
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
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

Last updated 2.20.19

Global Atlantic	Principal Life/DI	21st Services
Great America Life Ins. Co.	Principal National Life Ins. Co.	Other:_____
Guardian Life Ins. Co. of America	Principal National Life Insurance Company	
Habersham Funding, LLC	Progressive Capital	

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.

_____

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

_____

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