CBIZ Life Insurance Solutions, Inc.
10616 Scripps Summit Court, Suite 210
San Diego, CA 92131
P: 800.422.7536 | F: 858.444.3157
CA Agency License Number: OD48057
www.cbizlife.com

PRODUCER INFORMATION

Name:

Firm Name: Phone Number:

Email Address:

One Box Must Be Checked: ☐ Case is Exclusive with CBIZ Life Insurance Solutions ☐ Case is Being Shopped

If Being Shopped and/or Pending Application, Please Provide Name of Insurance Companies and Offers Received:

INFORMAL INQUIRY

Name: ☐ Male ☐ Female SSN:

Date of Birth: Citizenship: Driver's License State and Number:

Current Address:

City: State: Zip: Phone:

Occupation, Type of Business, Position: Net Worth: Annual Income:

Proposed Amount of Insurance: Premium Range:

Purpose of Insurance: Plan:

State of Policy Ownership: Is This a Replacement Policy? ☐ Yes ☐ No

IN-FORCE INSURANCE

Company Name	Replacement	Death Benefit	Plan	Year Issued	Current Premium	1035 Amount
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

Have You Ever Been Declined or Rated? If So, Please Explain:

Company Name	Year	Reason	Rating

MEDICAL HISTORY

Height: Weight: Have You Lost or Gained More Than 10lbs in the last 12 months? ☐ Yes ☐ No

If Yes, Please Provide Details Including How and Why?

Does Your Mother, Father or Sibling(s) Have a History of Cancer, Diabetes and/or Heart Disease? ☐ Yes ☐ No
If Yes, Please Indicate Type of History, Age at Onset, Current Age or Age at Death if Deceased.

Primary Physician Name:

Address:

City: State: Zip: Phone:

Specialist Physician: Phone:

Please List All Prescription and Over the Counter Medications and Dosages Currently Being Taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

Have You Ever Been Diagnosed With or Treated For Any of the Following (check all that apply)
If Yes, Please Give Details Below:

1 ☐ Heart Disease
2 ☐ Chest Pain Related to Cardiovascular Disease
3 ☐ High Blood Pressure
4 ☐ Heart Murmur
5 ☐ Stroke/TIA
6 ☐ Cancer
7 ☐ Diabetes
8 ☐ Lupus
9 ☐ Ulcerative Colitis or Crohn's
10 ☐ Respiratory Disorder
11 ☐ Kidney Disease
12 ☐ Hepatitis/Liver Disease
13 ☐ Nervous System Disorder Brain/
14 ☐ Spinal Cord DIsorder
15 ☐ Depression/Anxiety
16 ☐ Alzheimer's or Dementia
17 ☐ Other

Number:	Treatment/Prognosis/Details	Date of Onset/Date of Recovery	Treating MD Name (address and phone if not above) If Hospitalized Include Name/Address of Hospital

LIFESTYLE INFORMATION

Do You Currently Use: Cigarettes ☐ Yes ☐ No — If Quit, Years/Months Since Last Used:

Do You Currently Use: Cigars ☐ Yes ☐ No — If Yes, Frequency/Quantity:

Other Tobacco/Nicotine Products? ☐ Yes ☐ No — Provide Details:

Ever Convicted of a DUI? ☐ Yes ☐ No — If So, When (list all)?

Check If You Participate In Any of the Following Avocations:

☐ Aviation of Any Kind ☐ Extreme Sports ☐ Scuba Diving
☐ Mountain or Rock Climbing ☐ Sky Diving ☐ Motorcycle or Auto Racing

Do You Plan to Travel Outside of the US in the Next 12 Months? ☐ Yes ☐ No
If Yes, Please Provide Details Including Cities, Countries, and Length of Stay:

Exercise Habits:

Hobbies/Activities:

Community Involvement:

ADDITIONAL INFORMATION

Please Provide Any Additional Information You Feel is Necessary:

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name:_____ **Social Security:**_____ **Date of birth:**_____

Address:_____ **Telephone:**_____

Purpose: The purpose of this authorization is to ensure that Broker/Brokerage General Agency does not obtain, use, or disclose legally protected health or medical information about me, without my permission, or, for purposes other than those permitted by law.

Types of information for which my permission is requested: I understand that the following types of information may be obtained, used, and disclosed for the limited purposes identified herein: Personal health information (and medical records) concerning my past, present or future mental, physical or behavioral health or condition; the provision of all instances of healthcare or treatment, including all outpatient care and admissions; other insurance coverage; hazardous activities; character; general reputation; finances; occupation; avocation; motor vehicle driving record; personal traits; all information that I provided to broker about my finances and insurance needs during the "fact finding" process.

This information may also be described as nonpublic personal financial and health information: I further understand that the specific type of personal health information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or emotional illness, including treatment for alcohol or substance abuse (information protected by federal regulation 42 CFR Part 2), and serious communicable disease or infection, including sexually transmitted diseases; diagnosis, prognosis, and treatment of HIV infection, sometimes described as "AIDS Confidential Information".

Purpose for Disclosure: I understand that I am signing this Authorization for the purpose of allowing my Broker/Brokerage General Agency, to collect nonpublic personal financial and health information about me (information defined by and protected under applicable privacy law, including the Gramm-Leach-Bliley Act, the Health Insurance Portability and Accountability Act, and any other applicable state privacy law relating to nonpublic personal information) from the sources below, and to disclose such information to insurers (insurance and reinsurance companies) with whom Broker has established business relationships, in order to solicit non-binding insurance quotes on my behalf. "Solicitation of insurance quotes" includes the submission of information applications.

Persons Authorized to Make Disclosures: The following individuals and organizations are authorized to disclose my personal financial and health information to my broker: any physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically-related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any other non-medical information, including records or facts relating to employment, other insurance coverage, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal facts of me.

I, the Proposed Insured, authorize Broker to collect the types of information (described above) from the sources (described above), and I authorize the persons and organizations described as sources to release the types of information to Broker, or to any person authorized by Broker to assist with the collection of such information.

Persons to whom the disclosures may be made: The disclosures authorized and made pursuant to this authorization will only be made to the Broker for the purposes described herein. I also authorize Broker to release to the following insurers, including their insurers, reinsurers, or their legal representatives, and those other life and health insurance companies with whom broker is associated, my nonpublic personal and financial health information for the purpose as described above.

Accordia Life and Annuity
American General Life
American National Insurance
American National Life Ins of NY
Athene Life Insurance Company
Athene Life Insurance Co. of NY
AXA Equitable Life Insurance
Banner Life Insurance
Brighthouse Life Insurance Company
Brighthouse Life Insurance Company of New Yrok
Companion of New York
Fidelity Life
Genworth Life & Annuity
Genworth Life Ins. of NY
Genworth Life Insurance
John Hancock
John Hancock of New York Lincoln National Life Ins
Lincoln National Life Ins of NY
LTCI Partners
Minnesota Life
Nationwide Life & Annuity
Nationwide Life Insurance of NY
New York Life & Annuity Insurance
New York Life Insurance
Pacific Life & Annuity
Pacific Life Insurance
Penn Insurance & Annuity
Penn Mutual Life Insurance
Petersen's International Underwriters
Principal Life Insurance
Principal National Life Insurance
Protective Life & Annuity Ins of NY
Protective Life Insurance
Prudential Financial
Security Life of Denver Ins
Symetra
Transamerica Life Insurance Co.
The US Life Ins of NY
United of Omaha
VOYA Financial
William Penn Life Ins of NY
Windsor Insurance Services
Zurich American Life

CBIZ Life Insurance Solutions, Inc.
ASAP-APS
Express Imaging Services, Inc.
J&H Copy Services, Inc.
RSA Medical, LLC
Superior Mobile Medics

Amendment to Applicable Privacy Policy: I understand that the insurance companies with whom my broker deals have their own privacy policies respecting the collection, use and sharing of nonpublic personal information. I also understand that my nonpublic personal financial and health information is protected under the privacy policy of any company to which I disclose such information directly or indirectly. To the extent that this authorization conflicts with any applicable privacy policy of another insurer respecting the release of my nonpublic personal information to a nonaffiliated third party for marketing purposes, then I agree to treat this authorization as an amendment thereof, and I waive the benefits and protections thereof.

Expiration and Revocation: This authorization shall be valid for 30 months from the date of signing. This authorization may be revoked at any time by the submission of a written request for revocation, signed and dated by me. I understand that any actions taken in reliance on this authorization prior to its revocation cannot be reversed.

Re-disclosure: The information obtained through this authorization is subject to re-disclosure by the recipient of the information. However, if any information is re-disclosed, the protections provided herein will continue to be applicable, and the information will not be reused or disclosed, except as authorized by you, or as permitted by law.

Acknowledgements: I understand that I will be provided a copy of the executed authorization (or that I will have one provided to my authorized representative), and that a copy (photocopy or facsimile transmission copy) will be valid as the original. I also understand that broker may disclose some of my personal financial and health information to employees and contractors who perform services related to soliciting preliminary quotes and insurance offers and the underwriting of such offers and quotes. I understand that this authorization does not create or terminate and insurance coverage.

Record Retention: The insurance regulations of some states require that the licensee (Broker) retain an original or copy of this authorization for a period of six years from the date this authorization expires. I have read and understand the information contained herein, and by my signature below, authorize the receipt, use and disclosure of the information described herein, for the limited purposes described herein. No inducement has been made to compel my signature hereon. I understand that a health plan may condition enrollment in the health plan or eligibility for benefits on this authorization if I am not yet enrolled in the health plan, and if the purpose of this authorization is to allow the health plan to obtain the information it needs to make an eligibility, enrollment, underwriting, or risk rating determination and psychotherapy notes are not requested. If I refuse to sign this authorization, I may be denied enrollment in the health plan or eligibility for health care benefits.

Signature of Broker Date	Signature of Insured Date
Printed Name of Broker	Printed Name of Insured