

CPS INSURANCE SERVICES INFORMAL INQUIRY
9 Corporate Park Drive, Suite 100, Irvine, CA 92606-5129
Phone (800) 326-5433 Fax (800) 436-8255

Agent: Name _____ Phone _____ Fax _____ SS/Tax ID # _____ Email _____ Address _____		
Client: Name _____		
D.O.B. _____	Place of Birth _____	
Social Security # _____		
Resident Address _____ _____		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height ____ ft. ____ in.	Weight _____ lbs.
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Beneficiary Name and Relationship _____		
Plan of Insurance / Amount Desired _____		
How much life insurance in force now? _____		
Have you ever used any form of tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes, give form and frequency _____		
Has use been discontinued? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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	Reason	Date
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?			

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

CPS INSURANCE SERVICES

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: Medical Information Bureau, Inc., and/or Consumer Reporting Agency (3) Bureau: Medical Information Bureau, Inc.

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, except the Bureau, to give such records or knowledge to CPS Insurance Services.

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 (3) the Bureau or (4) 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.

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. I acknowledge receipt of the Notice to Proposed Insured - Parts I and II.

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

Proposed Insured Signature _____

Witness or Other Authorized Person Signature _____

AIG-American General / Ashar Group / AXA Equitable Life / Banner Life /
Chase / Companion / Empire General / Genworth Companies /
Indianapolis Life / ING Companies / Jefferson Pilot / John Hancock /
Lincoln Benefit / Lincoln Life / Mass Mutual / Mutual of NY / New York Life /
North American / Principal Financial / Prudential / Sun Life /
Transamerica / Travelers / United of Omaha /
U.S. Financial / West Coast Life / William Penn

Agent Instructions: The Notice To Proposed Insured (including FCRA and MIB notifications) appearing below must be given to the proposed insured before or at the time of signature.

NOTICE TO PROPOSED INSURED

(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.

AIG-American General / Ashar Group / AXA Equitable Life / Banner Life /
Chase / Companion / Empire General / Genworth Companies /
Indianapolis Life / ING Companies / Jefferson Pilot / John Hancock /
Lincoln Benefit / Lincoln Life / Mass Mutual / Mutual of NY / New York Life /
North American / Principal Financial / Prudential / Sun Life /
Transamerica / Travelers / United of Omaha /
U.S. Financial / West Coast Life / William Penn

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 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.

Medical Information Bureau (MIB) Inc. Disclosure Notice

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their re-insurer may, however, make a brief report thereon to the MIB, a non-profit membership organization of life insurance companies, which operates an informal exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the FCRA.

Credit Reporting Act. The address of the Medical Information Bureau's Office is Post Office Box 105, Essex Station, Boston, MA 02112, Phone (617) 426-3660. The companies listed in this Notice, or their re-insurer, may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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 9 CORPORATE PARK DRIVE, SUITE 100, IRVINE, CA 92606-5129.