



Trial Application

PERSONAL INFORMATION	Proposed Insured 1	Proposed Insured 2 (If applicable)
Full Name		
Address		
Phone Number	()	()
Date of Birth	/ /	/ /
Male/Female	Male ___ Female	Male ___ Female
Social Security Number	- -	- -
Driver's License/State		
Occupation		
Do you Smoke?	___ Yes, what and how much? ___ No, never smoked ___ No, but quit _____	___ Yes, what and how much? ___ No, never smoked ___ No, but quit _____
Height/Weight	___ Ft. ___ In. ___ Lbs.	___ Ft. ___ In. ___ Lbs.
Name, address and phone number of personal or attending physician		
	()	()
Medications you currently take		

HEALTH QUESTIONNAIRE					
So far as you know, within the past 10 years have you ever had:		Insured 1		Insured 2	
		Yes	No	Yes	No
a	Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or other disease or disorder of the heart or arteries?				
b	Diabetes or disease of any gland?				
c	Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?				
d	Arthritis, gout, or any bone, joint, muscle or skin disorder?				
e	Asthma, bronchitis, pneumonia, emphysema, or any lung disorder?				
f	Cirrhosis, hepatitis, ulcer, colitis, diverticulitis or any disorder of the liver or intestines?				
g	Prostate or testicular disease, disease of the uterus, ovaries or breasts?				
h	Anemia, leukemia, clotting disorders, platelet disorders, infections or sources of blood loss?				
So far as you know, within the past 10 years have you ever had:		Insured 1		Insured 2	

		Yes	No	Yes	No
i	Cancer or tumors?				
j	An operation or admission to a health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance?				
k	Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?				
l	Any other health impairment or medically treated condition?				
m	Use of narcotics, amphetamines, cocaine or any prescription drug except in accordance with physician's instructions?				
n	Treatment for alcohol or drug use of been advised to have such treatment by a doctor, licensed practitioner or any organization?				
o	A positive test result for exposure to the HIV infection, or been diagnosed as having ARC or AIDS or other sickness derived from such infection?				
p	Have you been admitted to a medical facility in the last two years?				
q	Is there a family history of cancer, diabetes, heart disease, or has either parent died prior to age 60?				
r	In the last two years, have you been unable to work or been disabled for one month or more?				
s	Have you ever engaged in any type of flying as a pilot or crew member; skin, scuba, or sky diving; auto or boat racing; or any intention of doing so?				
t	Do you have any intention of traveling or residing outside the United States or Canada during the next two years?				
u	Has any application for insurance been declined, rated, modified or postponed?				
v	Do you have any life insurance currently in force, or will be replacing? (Please also disclose if you have any policy loans or plan to take a policy loan to fund the new insurance)				

**Details for "Yes" answers to Health Questions
Proposed Insured 1**

Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone # of Attending Doctor/Hospital

**Details for "Yes" answers to Health Questions
Proposed Insured 2**

Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone # of Attending Doctor/Hospital

FINANCIAL INFORMATION

Income Information

Salary:	\$ _____	Total income:	\$ _____
Company pension:	\$ _____	Living expenses:	\$ _____
Social Security:	\$ _____	Taxes (State & Federal)	\$ _____
Investment income:	\$ _____	Gifts to family:	\$ _____
IRA distribution:	\$ _____	Federal income tax bracket:	_____
Other:	\$ _____	State income tax bracket:	_____

Financial Information (Attach a financial statement if available)

<u>Assets</u>	<u>Market Value</u>	<u>Cost Basis</u>	<u>Growth Assumption</u>	
Primary Home	\$ _____	\$ _____	_____%	Total Assets: \$ _____
Secondary Home	\$ _____	\$ _____	_____%	Less Liabilities: \$ _____
Real Estate	\$ _____	\$ _____	_____%	Net Worth: \$ _____
Business	\$ _____	\$ _____	_____%	Plus Personally Owned Life Ins.: \$ _____
Stocks	\$ _____	\$ _____	_____%	Taxable Estate: \$ _____
Mutual Funds	\$ _____	\$ _____	_____%	
Annuities	\$ _____	\$ _____	_____%	
Tax Free Bonds	\$ _____	\$ _____	_____%	
Money Markets	\$ _____	\$ _____	_____%	
Retirement Plans	\$ _____	\$ _____	_____%	
Notes Receivable	\$ _____	\$ _____	_____%	
Other	\$ _____	\$ _____	_____%	

Do you anticipate any inheritances? No Yes, estimated amount: \$ _____

Requested Plan of Insurance	
Type of Insurance Desired:	<input type="checkbox"/> Universal Life <input type="checkbox"/> Whole Life <input type="checkbox"/> Term <input type="checkbox"/> Survivorship <input type="checkbox"/> Variable <input type="checkbox"/> Other: _____
Insurance currently pending or applied for with all carriers:	
<u>CARRIER</u>	<u>AMOUNT</u>
<u>TYPE</u>	<u>STATUS</u>
Total Death Benefit to be placed:	\$ _____
Desired Premium:	\$ _____
Additional Dump In:	\$ _____
Source of Funds:	
Concept Information: (Purpose of the Insurance)	
<p style="text-align: center;">Personal</p> <input type="checkbox"/> Estate Planning <input type="checkbox"/> Charitable Contribution <input type="checkbox"/> Wealth Replacement <input type="checkbox"/> Income Replacement <input type="checkbox"/> Loan Securement Amount of Loan: \$ _____ <input type="checkbox"/> Other: _____	<p style="text-align: center;">Business</p> <input type="checkbox"/> Buy/Sell <input type="checkbox"/> Keyperson <input type="checkbox"/> Business Continuation <input type="checkbox"/> Loan Securement Amount of Loan: \$ _____ <input type="checkbox"/> Other: _____ Business Ownership %: _____ Gross Sales/Revenue: \$ _____ Expenses: \$ _____ Book Value of Company: \$ _____
How was the amount of insurance calculated:	

Agent Information	
Agent Name	
Agent Contact	
Address	
Phone Number	()
Fax Number	()
E-mail Address	
Social Security Number	



The Producers Group HIPAA RELEASE TO OBTAIN AND DISCLOSE INFORMATION

I understand that the life insurance companies named below, their reinsurers, life expectancy companies, any insurance support organizations and the authorized representatives of these companies may need to collect information on me in regard to proposed insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy or other medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person that has provided payment, treatment, or other services to me or on my behalf within the past 20 years to disclose to the insurance companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. To facilitate rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to The Producers Group, an affiliate of Freundt and Associates Insurance Services Inc.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health to include information on the treatment of Human Immunodeficiency Virus (HIV), infection and sexually transmitted diseases, drug and/or alcohol use, diagnosis or treatment of mental illness, character habits, avocations, finances, reputation, credit, or other personal traits.

The information will be used by the insurance companies named below and their reinsurers to determine eligibility and risk rating for insurance, claims and/or by the insurance agent to aide in updating and improving my insurance program.

Any protected health information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing and a copy of this Authorization is as good as the original. I understand that I may request to receive a copy of this Authorization.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices. I understand that if I refuse to sign this authorization to release my complete medical records, the insurance companies named below may not be able to process my application.

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I further understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person may re-disclose it to another party, at which time it may no longer be protected by federal confidentiality laws.

NOTICE TO PROPOSED INSURED

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 sources 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, 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 of the consumer reporting agency to which 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 a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies, which operates an informational 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 with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone (617) 426-3660.

The companies listed in this Notice or their reinsurers 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.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information, from others, such as medical professionals who have treated you.

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 a copy, if you wish, of 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 seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES, AND YOUR AGENTS INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, OR IF YOU WOULD LIKE TO REVOKE THIS AUTHORIZATION, PLEASE SEND YOUR REQUEST IN WRITING TO: The Producers Group, affiliate of Freundt and Associates Insurance Services Inc. Attn: Privacy Official.

21 st Services	Acacia Life	Allianz Life
Allstate Life of NY	American Equity	American General
American Investors	American National	Ameritas Life Insurance Company
AVIVA	AVIVA Life & Annuity NY	AVS
AXA Financial	Banner Life	Centrian Life
Companion Life	Examination Management Services , Inc.	Fasano Associates
Genworth Life Insurance Company	Genworth Life & Annuity Insurance Company	Guardian Life
Hartford Life Insurance Company	Industrial Alliance Pacific	ING
John Hancock	Lexnet LP	Life of the Southwest
LifeSecure	Lincoln Benefit Life	Lincoln National Life Ins Co
Mass Mutual	MetLife Investors	Minnesota Life
National Life Insurance Company	Nationwide Life	New York Life
North American	OMFN	Pacific Life
Penn Mutual Life Insurance Company	Phoenix Life	Presidential Life
Principal Life Insurance Company	Principal National Life Insurance Company	Protective Life
Protective Life & Annuity NY	Prudential	SBLI
Securian Life	Security Mutual Life of NY	Sun Life of Canada
Transamerica Life Insurance Co.	Transamerica Financial Life Insurance Co	Union Central
United of Omaha	US Life	West Coast Life
William Penn	Zurich American Life Insurance Company	

Signed at _____

Date _____

X _____
(Signature of Proposed Insured)

Name Proposed Insured (please print)