INDIVIDUAL INSURANCE SOLUTIONS

Informal Inquiry

Not an application for life insurance.

Producer Information

Name: _____

Firm Name: _____ Mobile Phone Number: _____

Email Address: _____

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

If being shopped and/or pending application, please provide name of insurance companies and offers recieved:

_____

Informal Inquiry

Name: _____ ☐ Male ☐ Female SSN: _____

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

Current Address: _____ Mobile Phone Number: _____

City: _____ State: _____ Zip: _____ Email: _____

Occupation, Type of Business, Position: _____ State of Policy: _____

Net Worth: _____ Annual Income: _____ Proposed Amount of Insurance: _____ Premium Range: _____

Ownership Type: ☐ Individual ☐ Trust ☐ Business Is This a Replacement Policy? ☐ Yes ☐ No

Policy Type: ☐ Individual ☐ Joint

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

Do you have access to patient portal through your primary care physician? ☐ Yes ☐ No

Height: _____ Weight: _____ Have you gained or lost 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: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Specialist Physician: _____ Phone: _____

Please list all prescriptions and over the counter medications and dosages currently being taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

Has your doctor recommended you have any additional or follow-up or pending appointments or tests? ☐ Yes ☐ No

If Yes, Please Explain: _____

_____

Have you ever been diagnosed with or treated for any of the following (check all that apply, may require additional information to assess)?

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 ☐ Sleep Apnea
18 ☐ Other

Number	Treatment/Prognonsis/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

Marijuana & CBD Oil Usage ☐ Check here if not applicable

Do you use marijuana? ☐ Yes ☐ No If yes, complete the following:

Purpose: ☐ Recreational/Social

Frequency: _____times per ☐ Day ☐ Month ☐ Year

Exact Type: _____ mg _____

Delivery Method: ☐ Ingested ☐ Vaporized ☐ Inhaled

Date Last Used: _____ Why: _____

Do you use use CBD oil? ☐ Yes ☐ No If yes, complete the following:

Frequency: _____times per ☐ Day ☐ Month ☐ Year

Exact Type: _____ mg _____

Delivery Method: ☐ Ingested ☐ Vaporized ☐ Inhaled

Date Last Used: _____ Why: _____

Tobacco/Nicotine Usage ☐ Check here if not applicable

Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, date of last usage: _____

Have you ever used vaping products (e.g. E-cigarettes)? ☐ Yes ☐ No If yes, date of last usage: _____

Have you used other tobacco or nicotine containing products (e.g. cigar, pipe, snuff, nicotine gum, or patch)? ☐ Yes ☐ No

If yes, provide type and date of last usage: _____

Describe your exercise routine, such as walking, running, treadmill, swimming, aerobics, strength training, cycling, sports or yoga.

_____

Type of Exercise	Frequency	Time Spent Per Session
	☐ Daily ☐ 1-3x/week ☐ 4-6x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3x/week ☐ 4-6x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3x/week ☐ 4-6x/week	_____ hours _____ minutes
	☐ Daily ☐ 1-3x/week ☐ 4-6x/week	_____ hours _____ minutes

☐ I do not participate in an exercise routine.

Check if you participate in any of the following avocations:

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

Lifestyle Information cont.

Have you ever had an application for life insurance declined, postponed, rated substandard, modified, requiring extra premium, or offered less than applied for by any company? ☐ Yes ☐ No

If yes, give details of decision type, reason, and date: _____

In the past 12 months, have you missed more than 10 consecutive days of work, school, or your daily/regular activities because of illness, injury, or medical treatment? ☐ Yes ☐ No

If yes, provide details: _____

_____

Do you plan to Travel Outside of the US in the Next 12 Months? ☐ Yes ☐ No

If Yes, give details of location (city/country), purpose, frequency and duration: _____

_____

Have you ever flown or intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes? ☐ Yes ☐ No

Please indicate any of the following activities you participate in or have participated in, within the last 2 years:

☐ Motorcycle racing	☐ Scuba diving	☐ Power boat racing	☐ Skydiving/parachuting
☐ Mountain climbing	☐ Ballooning	☐ Hang-gliding	☐ Backcountry skiing/snowmobiling
☐ Bungee/base jumping	☐ Heli skiing	☐ Motor vehicle racing	☐ I do not participate in any of these activities

Please indicate which of the following apply to your driving history:

☐ Convicted of 1 or more moving violations in the past 2 years ☐ Convicted of driving while intoxicated or otherwise impaired

☐ License is currently revoked or suspended ☐ None of these apply to me

Have you ever been convicted of a DUI? ☐ Yes ☐ No If so, when? Please list all. _____

_____

Have you ever been convicted of, plead guilty for, or are you currently awaiting trial for any infraction, misdemeanor, or felony?

If yes, give details of type, date, city/state of felony and/or crime and if currently on probation or parole: _____

_____

Additional Information

Please provide any additional information you feel is necessary: _____

_____

_____

_____

CBIZ is a consulting, tax and financial services provider that works closely with CBIZ CPAs P.C., an independent CPA firm that provides audit, review and other attest services.

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INDIVIDUAL INSURANCE SOLUTIONS

Authorization to Release Medical Information

Name: _____

Date of Birth: _____

Address: _____

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.

21st Services
Abacus Life
Accordia Life
Advantage Insurance Network, Inc.
Allianz
American National Insurance Co.
Ameritas
ASAP-APS
Assurity Life Insurance Co.
AVS, LLC
Balanced Strategies LLC
Banner Life
Brighthouse Financial
CBIZ Inc.
CBIZ Individual Insurance Solutions
Cincinnati Life Insurance Co.
Corebridge Financial (AIG)
Disability Insurance Services
Equitable
Evergreen Settlements
Exam One
F&G Life
Fasano Associates
Fidelity & Guaranty Life Insurance Co.
Financial Synergistics Group Inc.
First Insurance Funding
Genworth Life and Annuity
Genworth Life Insurance Co.
Global Atlantic
ISC Services
J&H Copy Services, Inc
John Hancock Life Insurance Co.
John Hancock USA
Legal & General America
Lighthouse Life Solutions, LLC
Lincoln Financial
Lincoln National Life Insurance Co.
Massachusetts Mutual
Minnesota Life/Securian
Mutual of Omaha/United of Omaha
National Life of Vermont
Nationwide Life & Annuity Co.
New York Life Insurance Co.
North American
OneAmerica
Pacific Life
Penn Mutual
Petersen International Underwriters
Premium Funding Group (PFG)
Principal Life Insurance Co.
Principal National Life Insurance Co.
Protective Life Insurance Co.
Prudential Life Ins Co./Pruco Life
Robin Glen, LLC
RSA Medical, LLC
Sagicor
SBLI
Succession Capital Alliance
Symetra
Transamerica Life Insurance Co.
William Penn Life Insurance Co.

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.

Acknowledgments: 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 the 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 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 induc ment 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 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 Insured Date

_____

Printed Name of Insured

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