CPS IMIS
INTEGRATED MARKETING & INSURANCE SERVICES

INFORMAL INQUIRY – Not an application for insurance

CLIENT INFORMATION			
Client Name:	Date of Birth:	SSN:	
Address:	City:	State:	Zip:
Sex: ☐ Male ☐ Female	Birth State / Country	Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow	
Occupation:	Annual Income:	Net Worth:	

PRODUCER INFORMATION		
Producer Name:	Phone:	SSN:
Address:	E-Mail:	

GOALS	**Plan Type (select all that apply): ☐ Term ☐ GUL ☐ UL ☐ IUL ☐ VUL ☐ WL ☐ SUL**	
Term Level Period: ☐5yrs ☐10yrs ☐15yrs ☐20yrs ☐30yrs	Guarantees to age:	Riders: ☐ LTC ☐ Disability Waiver ☐ ROP ☐ Other:
Face Amount:	UW Rate Class:	Max Annual Premium Budget:
Purpose of Insurance (Select all that apply) ☐ Income Replacement ☐ Estate Preservation ☐ Key Person ☐ Buy/Sell ☐ Other:		
Additional Comments:		

EXISTING AND APPLIED FOR INSURANCE **Does the client have any existing or applied for life insurance? ☐ Yes ☐ No**

Name of Company	Amount	Current Status	Year	Annual Premium	Replacement	Reason for Rated or Declined
		☐ Pending ☐ Inforce			☐ Yes ☐ No	
		☐ Pending ☐ Inforce			☐ Yes ☐ No	
		☐ Pending ☐ Inforce			☐ Yes ☐ No	

BUILD AND TOBACCO USE		**Ever used any form of tobacco/nicotine? ☐ Yes ☐ No**
Height: ft. in.	Weight: lbs.	If weight has changed in the past 12 months – ☐ Gain lbs. ☐ Loss lbs. Reason:
How long since last used any form of tobacco/nicotine: Yrs. Months. ☐ Never		Frequency of use:
Type of use: ☐Cigarette ☐Cigar ☐Pipe ☐Vape ☐Hookah ☐Marijuana ☐Smokeless ☐Chewing Tobacco ☐Patch/Gum ☐Other:		

FAMILY HISTORY **Has a parent/sibling ever had: ☐ heart disease, ☐ coronary artery disease, ☐ stroke, diabetes, ☐ cancer? ☐ Yes ☐ No**

Relationship to Proposed Insured	Age(s) if living	Age(s) at Death	Age(s) of Onset	**Specific Condition or Cause of Death**

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MEDICAL HISTORY

☐ High Blood Pressure	☐ High Cholesterol	☐ Coronary Artery Disease	☐ Heart Attack
☐ Cardiac Chest Pains	☐ Arrhythmia/Irregular Heartbeat	☐ Heart Murmur/Valvular Heart Disease	☐ Heart Failure
☐ Peripheral Vascular Disease	☐ Stroke/Transient Ischemic Attack	☐ Diabetes	☐ Disorder of the Thyroid/Other Gland
☐ Cancer: Type: _____	☐ Leukemia/Lymphoma	☐ Benign Tumor/Polyp	☐ Anemia/Blood Disorder
☐ Autoimmune Disorder	☐ Asthma	☐ COPD	☐ Sleep Apnea
☐ Seizures/Epilepsy	☐ Tremors	☐ Parkinson's Disease	☐ Multiple Sclerosis
☐ Cognitive Impairment/Memory Loss	☐ Alzheimer's Disease	☐ Depression	☐ Anxiety
☐ Bipolar Disorder	☐ Ulcers	☐ Hepatitis	☐ Cirrhosis
☐ Crohn's/Ulcerative Colitis	☐ Barrett's Esophagus	☐ Rheumatoid/Psoriatic Arthritis	☐ Fibromyalgia
☐ Osteoarthritis / Osteoporosis	☐ Kidney Disease	☐ Disorder of the Bladder/Urinary Tract	☐ Disorder of the Prostate
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

Comments: _____

PHYSICIAN INFORMATION

Primary Physician

Name	Address and Phone	Date Last Seen	Reason last seen and results
	Address: _____ _____ Phone: _____		

Physician(s) consulted in the past 10 years

Name	Address and Phone	Date Last Seen	Reason last seen and results
	Address: _____ _____ Phone: _____		
Name	**Address and Phone**	**Date Last Seen**	**Reason last seen and results**
	Address: _____ _____ Phone: _____		

CLIENT MEDICATION INFORMATION

Currently taking medications? ☐ Yes ☐ No

Prescription Medication	Condition Treating	Name, Address and phone number of prescribing physician.

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured:	Date of Birth:

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: Consumer Reporting Agency.
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 regarding 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 to give such records or knowledge to CPS Insurance Services. The protected health information is to be disclosed under the Authorization at my request, as permitted by 164.508©(1) (iv) of the Health Insurance Probability and Accountability Act (HIPAA) Privacy Rule.
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 or (3) 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.

_____ (initial) I understand that I or my authorized representatives may request to receive a copy of this Authorization.

_____ (initial) 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: _____

Agile · Allianz · American National · Assurity · Banner Life · Cincinnati - Corebridge Financial · Coventry · Equitable · Global Atlantic · Illinois Mutual · John Hancock · Lincoln Life · Magna · MassMutual · National Life · New York Life · North American · Pacific Life · Petersen International · Principal Life · Principal National Life · Protective · Prudential · Securian · The Standard · Symetra · Transamerica · United of Omaha · William Penn

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NOTICE TO PROPOSED INSURED - PART I

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.

INFORMAL INQUIRY

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.

NOTICE TO PROPOSED INSURED - PART II

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 if 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 to 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.

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 2860 MICHELLE DRIVE, SUITE 150 IRVINE, CA 92660.

They may disclose this information to: (1) other insurers to which I have applied or may apply (2) reinsurer or (3) 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.