



CPI Companies

513 Centennial Blvd.
Voorhees, NJ 08043
P. 856-874-1250
F. 856-874-1255

www.cpicompanies.com

The Underwriting Specialists

PRELIMINARY APPLICATION

Please use (1) application per insured

Submitting Agent: _____

Personal Data

Name of Insured: _____ e-mail: _____

Address: _____

City/State/Zip: _____

Phone: _____ Cell: _____ Best time to call: _____

Gender: () **Male** () **Female** Date of Birth: _____ SS#: _____

Tobacco Use: **Yes** () **No** () Type: _____ Frequency: _____

Face Amount: _____ Corp/Personal Owner: _____ Replacement: () **Yes** () **No**

Type of Coverage (check all that pertains): **Individual** () **Survivorship** () **Term** () **Permanent** ()

If Survivorship, please provide spouse details: _____

Medical History

Current Medications: _____

Personal Physician _____ Phone _____

Date & Reason Last Seen _____

Address _____

City/State/Zip _____

Name of other physicians and/or medical facilities that you have seen in the past (5) years (use additional paper if needed):

Physician Name _____ Phone _____

Date & Reason Last Seen _____

Address _____

City/State/Zip _____

Physician Name _____ Phone _____

Date & Reason Last Seen _____

Address _____

City/State/Zip _____

HIPAA Compliant Authorization for Release of Information

I (Patient/Insured) _____ authorize _____ and/or any licensed physician, healthcare professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, insurance company, Medical Information Bureau (MIB), or any other organization, institution or person that has any records or knowledge of me or my health within the past 10 years, including my entire medical records, pharmaceutical records and any other information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to disclose such information, including my entire medical records and any other protected health information concerning me to Comprehensive Insurance Programs, Inc., as well as the aforementioned life insurance companies and their reinsurers, when necessary. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis or treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical records without restriction. I understand that upon disclosure to any person or organization that is not a health plan or healthcare provider, the information may no longer be protected by federal privacy regulations.

This authorization shall remain in force for 36 months following the date of my signature below, *and that a photocopy or facsimile of this authorization has the full force and effect as the original.* I understand that I have the right to revoke this authorization in writing, at anytime by sending a written request for revocation to Comprehensive Insurance Programs, Inc., 513 Centennial Blvd., Voorhees, NJ 08043. I understand that a revocation does not apply to information that has already been released in response to this authorization.

I also acknowledge receipt of the notices required by the Fair Credit Reporting Act, which are printed below this authorization. I have been informed of my right to receive a copy of this authorization. I am aware I may be required to complete another application before coverage can be put into effect.

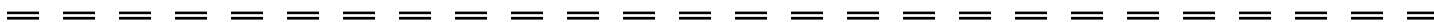
I reserve the right to request that Comprehensive Insurance Programs release my medical records to me upon receipt of my written authorization to do so. I hereby release Comprehensive Insurance Programs, Inc from any liability related to the release of my medical records directly to me.

The Fair Credit Reporting Act Notification

In compliance with the Public Law 90-508 (Fair Credit Reporting Act), I understand that part of the underwriting procedure, any life insurance company may secure on me a routine inquiry involving interviews regarding my character, general reputation, personal characteristics, etc. I further understand that upon written request from me, additional information will be provided concerning the nature and scope of such inquiry, if one is actually made.

Patient/Insured Printed Name: _____ DOB: _____

Patient/Insured Signature _____ Date: _____



Insurance Company Affiliations

**AIG/American General Life Ins
American National Insurance Co.
Argus
AVIVA
AXA Equitable
Banner Life Insurance Co.
Berkshire
Branca-Rampart Agency
Columbus Life
F&G Life Insurance
Five Oceans Life
Guardian
Genworth Financial companies
Hartford Life & Annuity Co.**

**HCC Specialty Underwriters, Inc.
John Hancock
Lighthouse Life
Lincoln Benefit Life
Lincoln Financial Group
Lloyds of London
MetLife
Minnesota Life
Mutual of Omaha
Nationwide Financial
New York Life
Pacific Life Insurance Co.
Panamerican
Petrone Associates**

**Phoenix Life
PMA Administrative Services
Principal Life
Prudential Insurance Co
Security Mutual
Standard Insurance Company
Sun Life Financial
Transamerica Life Insurance
U.S. Commonwealth Life A.I.
Union Central Life
West Coast Life / Protective Life
William Penn Life
Zurich**