

AGENT'S NAME: _____

AGENT'S PHONE: _____ AGENT'S FAX: _____

CLIENT'S NAME	PLAN OF INSURANCE
D.O.B.	AMOUNT DESIRED
PLACE OF BIRTH	BENEFICIARY (Name & Relationship)
SOCIAL SECURITY NUMBER	
RESIDENT ADDRESS	HOW MUCH INSURANCE IN FORCE NOW?
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT _____ FT. _____ IN. WEIGHT _____ LBS.

Has this case been submitted to other companies in the past six (6) months? YES NO
If yes, list companies, file numbers and dates submitted.

LIST ANY INSURANCE THAT WAS APPLIED FOR THAT WAS RATED OR DECLINED						
NAME OF COMPANY	AMOUNT	YEAR	STD. PREMIUM	INSURED?	EXTRA PREMIUM	REASON Rated or Declined

	Name and Address	Reason	Date
What physician did you last consult? (other than insurance exam)			
In what hospitals, clinics or sanitariums have you been treated?			
Who is your personal physician?			
When was your last consult?			
Have you ever used any form of tobacco? <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, give forms and frequency:</i>		
Has use been discontinued? <input type="checkbox"/> YES <input type="checkbox"/> NO	<i>If yes, please detail, date and reason:</i>		

Notice to Proposed Insured – Part I
Notice of Insurance Information Practices – In the course of property 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 the preparation of 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 see copies of your personal information which appears in the insurance companies' files, including information contained in investigative consumer reports. You also have the right to correct information you believe to be inaccurate.

CREDIT REPORTING ACT
 P.O. Box 105, Essex Station, Boston, MA 02112, Phone: 617.426.3660

The companies listed in this notice, or their reinsurer, may also release information in their file 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.

HIPAA Compliant Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to: _____
Insurance Company

The purpose of this disclosure is to evaluate my application for insurance or claim benefits. I hereby authorize for you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Medical Facility Name: _____

Address: _____

City/State/zip: _____

To release any and all records and information regarding:

Patient's Name: _____

Other Names Used: _____

Date of Birth: _____ Social Security Number: _____

Specifics to be released: _____

To be released to and exchanged between the insurance company first named above, and:

and their agents, contractors, employees, representatives, affiliates, and assigns as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this application, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below. I understand I may revoke this Authorization at any time by requesting this in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release my complete medical records, my insurance company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any benefit payments.

SIGNATURE: _____ **Date:** _____

(Patient, Guardian*, or Authorized Representative*)

*Please provide documents to prove authority to sign on behalf of the patient

Abacus Settlements
American General Life Companies
American National
Assurity Life Insurance
Aviva Life & Annuity Company
Banner Life
Berkshire Settlements
Cincinnati Life
Coventry Financial
Fidelity Life Association
Genworth Life Insurance Company

Genworth Life & Annuity Insurance
Company
Great West Growth
Habersham Funding
Independent Funding Group
ING
JG Wentworth
John Hancock
Liberty Life
Lincoln Benefit Life
Lincoln National Life
Maple Life Financial
MetLife Investors

Neuma, Inc.
Peachtree Life Settlements
Principal Life
Prudential
RBC Insurance
Reliastar
Security Life of Denver
Transamerica
Union Central / Ameritas
VESPERS Financial Group
Welcome Funds
West Coast Life

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic 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 to furnish to the insurance companies named above the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to evaluate my insurance application to Appletree Financial Network, Inc. I authorize my current insurance company to furnish Appletree Financial Network, Inc. and/or its authorized representatives with any information and forms in connection with my policy including any conversions or replacements thereof.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit or other personal traits.

The 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 above, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I understand that I may request to receive a copy of this Authorization. I acknowledge receipt of the Notice to Proposed Insured.

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

Print Name _____

Signature _____

AGENT INSTRUCTIONS: The notification appearing below must be given to the proposed insured before or at the time of signature.

Notice To Proposed Insured

Federal Fair Credit Reporting Act Notice

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 any investigative consumer report was made. The consumer-reporting agency, upon request, will furnish information as to the nature and scope of this investigation. You have the right to inspect and receive a copy of any such report by contact in the consumer-driven agency.

MIB Disclosure Notice

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurer may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit member organization of life insurance companies, which operates an informational exchange 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 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 Federal Fair Credit Reporting Act.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LIFE 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:

APPLETREE FINANCIAL NETWORK, INC. 8101 34th AVE S, SUITE 380, BLOOMINGTON, MN 55425