TRUST FINANCIAL SERVICES
YOUR TRUSTED SOURCE FOR LIFE SOLUTIONS

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Preliminary Inquiry

This is not an application for life insurance. This form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

TFS Account Executive: _____ Phone:_____

Personal History - (this section must be completed)

Name_____ Male Female Soc. Sec#_____

Address _____City _____ State _____ Zip _____

Date of Birth _____ Age _____ Height _____ Weight _____

Monthly Earned Income $_____ Occupation _____

Tobacco/Nicotine Usage

1. Have you ever smoked cigarettes: Y / N if yes, date of last usage: _____
2. Have you used other tobacco or nicotine containing products: Y / N (examples: cigars, pipe, snuff, nicotine gum or patch) If yes, provide types and last date of use: _____
_____

Has case been submitted to other companies in the past 6 months? Y / N
If yes, list companies, file #s, dates submitted and offers made:
Company: _____ File # _____ Date: _____
Company: _____ File # _____ Date: _____
Company: _____ File # _____ Date: _____

Agent Information - (this section must be completed)

Name _____Soc. Sec. # _____ Phone No. _____
Address _____ City _____ State _____Zip _____
Fax No. _____ Email Address _____

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Proposed Insured: _____ Soc. Sec. _____

Minimum Consideration: $500,000 face amount and/or minimum premium of $2,500
Universal Life Whole Life Term, Level Period _____ Survivorship
Annuity LTC Disability Income, Monthly Benefit Amount_____
Face amount desired: _____Premium amount desired: _____
Will these premiums be financed? Y / N / Possibly (*circle one*)

If you are replacing coverage, will there be any 1035 money with this replacement? Y / N
If yes, what amount will be carried over? $_ _____
What is the purpose of the insurance? _____

Provide details on pending and in-force coverage:

COMPANY	POLICY DATE	AMOUNT	RATE CLASS	CURRENT PREMIUM	REPLACEMENT
					Y / N
					Y / N
					Y / N
					Y / N

Medical History - (this section must be completed)

Who is your primary care physician? When did you last consult him/her? Why?	Doctor's name/address/phone #	Date	Illness
What other physicians have you consulted during the past five years? Why?			

Proposed Insured: _____ Soc. Sec. _____

Medical History (continued) - (this section must be completed)

In what hospitals, clinics, or other health facilities have you ever been treated?	Date	Illness
Please list all current medications.		

Family History - (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Y / N If yes, please provide the following details:

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(If deceased) Age at death

Proposed Insured: _____ Soc. Sec. _____

Drug & Alcohol Usage

Do you currently drink alcohol? Y / N Date of last consumption: _____ Note amount below.		Did you ever drink substantially more than present? Y / N If yes, when?_____ Note amount below.	
Type:	**Amount per week:**	**Type:**	**Amount per week:**
Beer		Beer	
Wine		Wine	
Liquor		Liquor	

Have you ever consulted a doctor or received treatment because of your alcohol use? Y / N
Have you ever been arrested for driving under the influence of alcohol? Y / N
If yes, provide date(s):_____
_____

Have you ever used illegal drugs or sought treatment because of drug use? Y / N
If yes, provide details:
Types of drug(s) used:_____
Date of last use:_____
Doctor/Facility name and address: _____

Coronary

1. Date of diagnosis or first chest pain: _____ -_____-_____
2. Number of diseased vessels:_____
3. Dates/details of treatment/surgery (examples: Angioplasty, Bypass)

_____
_____
_____

4. Date of last stress EKG:_ _____-_____-_____
Results: _____
By whom? _____
5. Any pain since treatment/surgery? _____

Proposed Insured: _____ Soc. Sec. _____

Cancer

1. Exact name and location of cancer: _____
_____
2. Stage and grade:_____
_____
3. Who would have the pathology report?_____
4. Dates/details of treatment/surgery: _____
_____

Diabetes

1. Date of diagnosis:_____ -_ _____ -_ _____
2. Treatment: (circle one) Diet Only Oral Medication Insulin
Details:_____
3. Do you regularly test your blood glucose? Y / N
Results:_____ Frequency:_____
4. Latest result of glycohemoglobin (A1C) test:_____ mg%
Date:_____ -_ _____ -_ _____
5. Have you been diagnosed with having protein and/or microalbumin in your urine? Y / N
6. Have you EVER had:

a. any eye trouble?	Y / N	d. kidney trouble?	Y / N
b. heart trouble?	Y / N	e. neuritis/neuralgia?	Y / N
c. high blood pressure?	Y / N	f. insulin reactions?	Y / N

Hazardous Activities

Are you a private pilot? Y / N If yes, provide details below.
How many total hours have you flown as Pilot in Command?_____
How many hours do you fly per year?_____
Do you have an IFR (instrument flight rating)? Y / N

Do you participate in the following activities? (circle those that apply)

Scuba Diving Bungee Jumping Ultralight Flying Sky Diving

Mountain Climbing Hang Gliding Auto/Motorcycle Racing Other_____

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 in regard to 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 Trust Financial 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.

Re-disclosure: I understand that once health information I have authorized to be disclosed reaches the party(ies) indicated, that person or organization may re-disclose it, at which time it may no longer be protected under privacy laws.

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. _____ (initial)

Signed at: _____this _____ day of _____, 20_____.

Proposed Insured Signature:_____

Witness or Other Authorized Person Signature:_____

Accordia / AIG-American General / Allianz / Allstate Life of NY / American Mayflower / American National / AXA / Banner Life / Bankers Life of NY / Companion Life / Fidelity Life / Genworth Companies / Guardian/ Hartford / ING Companies / Indianapolis Life / John Hancock / Liberty Life / Lincoln Benefit / Lincoln Life / Mass Mutual / Med America / Met Life / Minnesota Life / Mutual of Omaha / National Western / Nationwide / New York Life / North American / Old Mutual Financial Network / Penn Mutual / Phoenix / Principal Life Insurance / Principal National Life Insurance / Protective / PRUCO Life Insurance Company / Prudential Insurance Company of America / Reliastar Life Ins Co / Reliastar Life of NY / SBLI / Securian Life / Sun Life / Sun Life of NY / Symetra / Transamerica / United of Omaha / US Life / VOYA / West Coast Life / Western Reserve / William Penn/Zurich American Life Insurance Co./Zurich American Life Insurance Co. of NY

Proposed Insured: _____ Soc. Sec. _____

***** IMPORTANT *** IMPORTANT *** IMPORTANT *****
AGENT INSTRUCTIONS: THE FCRA NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

---------- Perforate or Cut Here ----------

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 whether or not 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 TRUST FINANCIAL SERVICES AT 147 COLUMBIA TPKE. SUITE 109, FLORHAM PARK, NJ 07932.