CAVALIER ASSOCIATES, LLC
CAVALIER INSURANCE MARKETING SERVICES, LLC
2801 TOWNSGATE ROAD, SUITE 350, WESTLAKE VILLAGE, CA 91361
TEL: (800) 350-2019 FAX: (805) 371-4899

Preliminary Inquiry – Page 1 of 2

CONFIDENTIAL - NOT AN APPLICATION FOR INSURANCE

PERSONAL INFORMATION

Name	Male	Female	Social Security Number
	☐	☐	

Address, City, State, Zip

Date of Birth	Citizenship	Age	Height	Weight

Occupation	What are your Duties?

Annual Earned Income	Annual Unearned Income	Net Worth	Phone
$	$	$	

When did you last use any tobacco products?_____Details: _____

Type of tobacco used: ☐Cigarettes ☐Chewing Tobacco ☐Other: _____
☐Cigars ☐Pipe

Does your driving history contain any moving violations or license suspensions? ☐Yes ☐No

If yes, details: _____

Avocation Activities: Private Pilot? ☐Yes ☐No Sky Dive? ☐Yes ☐No Mountain Climb? ☐Yes ☐No
Scuba Dive? ☐Yes ☐No Hang Glide? ☐Yes ☐No Auto/Motorcycle Race? ☐Yes ☐No

Details: _____

Family Health History:	Age if living	Age at death, if deceased	History of heart disease, stroke, circulatory disorder, kidney disease?	History of cancer (all types)?
Mother	_____	_____	☐Yes ☐No	☐Yes ☐No
Father	_____	_____	☐Yes ☐No	☐Yes ☐No
Sister(s)	_____	_____	☐Yes ☐No	☐Yes ☐No
Brother(s)	_____	_____	☐Yes ☐No	☐Yes ☐No

Have you ever sold a policy as a "Life Settlement" in the secondary market? ☐Yes ☐No
Have you ever been declined for coverage or been rated? ☐Yes ☐No, If yes, please complete the following:

Company	Coverage Amount	Issue Date	Rating	Plan Type	Surrender Value

PLAN OF INSURANCE

☐Term ☐Whole Life ☐Universal Life ☐Indexed UL ☐Variable Universal Life
☐Individual ☐Survivorship Face Amount $_____ Premium $_____

Owner	Beneficiary	Relationship

Is this case currently being shopped through another Brokerage General Agency? ☐Yes ☐No
Is this case currently being reviewed by any insurance carrier? ☐Yes ☐No If yes, which carrier(s)?_____

What offers, ratings, or declinations have you received on this case? (Please list offers and carriers):
_____

IN FORCE INSURANCE

Total amount in force $_____ Pending insurance? ☐Yes ☐No Date of last application:_____

Company(s):_____

Is existing insurance coverage being replaced? ☐Yes ☐No If yes, total coverage being replaced $_____

Company(s):_____

AGENT INFORMATION

Name	Firm

Phone	Fax	Email

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MEDICAL HISTORY – THIS INFORMATION MUST BE COMPLETED WITH ALL KNOWN INFORMATION

Please indicate your personal physician: Name: _____ Date(s) Seen: _____

Reason(s) Seen: _____

Doctor's Street Address	City	State	Phone

Please list ALL other physicians you consulted or been seen by over the past five years, including any specialists:

Name: _____ Date(s) Seen: _____

Reason(s) Seen: _____

Doctor's Street Address	City	State	Phone

Name: _____ Date(s) Seen: _____

Reason(s) Seen: _____

Doctor's Street Address	City	State	Phone

Additional (Attach additional pages if necessary): _____

Please indicate any hospitals or clinics in which you have been treated: _____

Date(s) Seen: _____ Reason(s) Seen: _____

Hospital or Clinic Street Address	City	State	Phone

Please list all current medications: _____

_____

Has anyone proposed for coverage been diagnosed with or treated by a member of the medical profession for:	**Yes**	**No**
Chest pain, shortness of breath, heart murmur, blood pressure, stroke, irregular heart beat, or any other disease or disorder of the heart or arteries?	☐	☐
Diabetes or disease of any glands?	☐	☐
Mental, emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?	☐	☐
Arthritis, gout, or any bone, joint, muscle or skin disorder?	☐	☐
Asthma, bronchitis, pneumonia, emphysema or any lung disorder?	☐	☐
Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?	☐	☐
Prostate or testicular disease, disease of the uterus, ovaries or breast?	☐	☐
Anemia, leukemia, clotting disorders, or platelet disorders?	☐	☐
Disorder of the urinary tract or kidneys – sugar, albumin or blood in the urine?	☐	☐
Cancer or tumors?	☐	☐
An operation or admission to a hospital or any other health care facility for observation, treatment of any illness (excluding HIV) or diagnostic tests (including treadmill stress test for insurance?)	☐	☐
Any other health impairment or medically treated condition not previously mentioned?	☐	☐
Within the last 10 years have you been diagnosed by a doctor as having Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

PLEASE PROVIDE DETAILS TO ANY "YES" ANSWERS TO THE QUESTIONS ABOVE in the space below. Attach additional pages if necessary. Please be specific with this information, and include phone numbers.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Proposed Insured's Name	Date of Birth	Social Security Number	**This form is HIPAA compliant**

Records and information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Cavalier Associates, LLC, Cavalier Insurance Marketing Services, LLC, Advantage Insurance Network, Inc., brokers, contractors, employees, representatives and agents working through Cavalier Associates, LLC or Cavalier Insurance Marketing Services, LLC for purposed of the Proposed Insured applying for or evaluating insurance coverage.

Insurance Companies and Agencies

Accordia Life	**Fidelity & Guaranty Life Ins. Co.**	**Lafayette Life**	**Pacific Life**
Abacus Settlements	**First Heartland**	**Life Insurance of the Southwest**	**Pan-American Life Insurance Group**
Advantage Insurance Network, Inc.	**First Insurance Funding**	**Lincoln Benefit Life**	**Penn Mutual**
Allianz	**First Penn**	**Lincoln Financial/ Lincoln Life**	**Phoenix Life**
American General Life (AIG)	**Foresters**	**Lincoln National Life Insurance Co.**	**Principal Life**
American General Life & Accident	**General American Life Ins. Co.**	**Massachusetts Mutual**	**Principal National Life**
American National	**Global Atlantic Financial Group**	**Metropolitan Life**	**Protective Life Ins Co.**
Americo	**Global Insurance Underwriters**	**MetLife Investors USA Insurance Co.**	**Prudential Life Ins. Co. / Pruco Life**
Apeiron Gate	**GE Financial Assurance Co.**	**Miami Life Insurance Services**	**Sagicor**
Assurity Life	**Genworth Life Insurance Co.**	**Minnesota Life / Securian**	**SBLI**
Ameritas	**Genworth Life and Annuity**	**Mutual of Omaha**	**Security Mutual**
AVS, LLC	**Guardian Life Ins. Co.**	**National Brokerage Atlantic**	**Standard Life**
AXA / MONY / AXA Equitable	**Hartford Life Insurance Co.**	**National Life of Vermont**	**Superior Medical Group**
Balanced Strategies, LLC	**Voya / ING - ReliaStar Life of New York**	**National Western**	**Symetra**
Banner Life	**Voya / ING – ReliaStar**	**Nationwide Life & Annuity Co.**	**Transamerica Life Insurance Co.**
Brighthouse Life Insurance Company	**Voya / ING – Security Connecticut Life**	**New Investor World, Inc.**	**Union Central Life**
Cavalier Associates, LLC	**Voya / ING - Security Life of Denver**	**New York Life Insurance Co.**	**United of Omaha**
Cavalier Insurance Marketing Services, LLC	**Jetstream APS**	**North American Company for Life & Health Insurance**	**USG Annuity & Life**
Columbus Life	**John Hancock Life Ins. Co.**	**Old Mutual Financial Network**	**Western Reserve Life**
Corebridge Financial	**John Hancock USA**		**William Penn Life Ins. Co.**
Examination Management Services, Inc.			**Zurich American Life Insurance Company**

Additional Insurers and Agencies:

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician listed below,

Physician Name: _____

Physician Address: _____,
any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to Cavalier Associates, LLC, Cavalier Insurance Marketing Services, LLC, the Insurers and Agencies listed afore and to: Agent/Producer Name:_____.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. The information will be used by the insurance and/or settlement companies named below and their reinsurers to determine eligibility for insurance and/or by the insurance agent to aid in updating and improving my insurance program. The information collected may be disclosed to other insurance companies to which I have applied or may apply, settlement companies, reinsurance companies, or other persons or organizations performing business, professional, or insurance functions for the insurance and/or settlement companies named below, or as may be otherwise legally allowed.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ this _____ day of _____ 20_____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative

X_____Printed Name: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

NOTICE TO PROPOSED INSURED

Instructions to the Agent/Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek 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. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the 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 that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.
EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.