



DATASOURCE

Preliminary Inquiry

PO Box 71339 Salt Lake City UT 84171-0339
 801-713-0800 Toll Free 888-888-7441
 Fax 801-713-0805 Toll Free Fax 888-888-7449
 Email IRmail@uproducers.net
This is not an application for Life Insurance

Full name of Client		<input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____	
Date of Birth	State Of Residence	<input type="checkbox"/> Non Smoker <input type="checkbox"/> Tobacco User <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chews <input type="checkbox"/> Cigars	
Occupation <input type="checkbox"/> Retired		Result of last life Insurance application: Year _____ <input type="checkbox"/> Preferred <input type="checkbox"/> Standard <input type="checkbox"/> Rated <input type="checkbox"/> Declined	
If disabled, please list cause		List Company _____	

Plan of Insurance Universal Life Whole Life Term Level Period 10 15 20 Other _____

Amount \$ _____ **Premium Limit** _____ **Mode** A S A Q Mo

Client Health Information Important: In this section please list all major illnesses in the last ten years . On page 2 please list all doctors, clinics and hospitals, along with all prescription medication currently being taken.

illness	Year of onset	Year of last treatment	Was surgery involved?	Do you have implanted a pacemaker or defibulator

Agents Information

Name	Address, City, State, Zip
Telephone	Fax
Email	

NOTICE OF 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. The companies may also seek information from others, such as medical professional 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 the 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 companies' files, including information contained in investigative consumer reports.

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 seek correction of information you believe to be inaccurate.

FOR A DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO CPS/UNITED INSURANCE SERVICES.

- United Producers Inc.
- CPS/United Ins. Services
- CPS Insurance Services
- CPS Settlements
- American General Life
- American Mayflower
- American National
- AXA/Equitable/MONY
- Bankers Life of NY
- Banner Life
- Chase Insurance
- Companion Life of NY
- Fidelity Life Association

- Genworth Financial
- Guarantee Trust Life
- Hartford Life
- ING Companies
- Illinois Mutual
- Indianapolis Life
- Jefferson Pilot
- John Hancock
- Life of the Southwest
- Lincoln Benefit Life
- Lincoln Financial
- Mass Mutual
- MetLife

- MetLife Investors
- Mutual of Omaha
- Nationwide
- New York Life
- North American Life & Health
- Old Mutual Financial Network
- Phoenix Life
- Presidential Life
- Principal Financial
- Protective Life
- Prudential Financial
- Reliastar Life
- Sun Life Financial

- Transamerica
- United Home Life
- United of Omaha
- US Life
- West Coast Life
- Western & Southern Life
- Western Reserve Life
- William Penn

PLEASE LIST ALL DOCTORS, HOSPITAL AND CLINICS THAT HAVE TREATED YOU IN THE LAST 5 YEARS

Illness: _____ **Onset:** Month _____ Year _____

Physician: _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

Illness: _____ **Onset:** Month _____ Year _____

Physician: _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

Illness: _____ **Onset:** Month _____ Year _____

Physician: _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

Illness: _____ **Onset:** Month _____ Year _____

Physician: _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

HOSPITALS & CLINICS (Visited in Last 5 Years, if cancer was involved 20 years.)

Illness: _____ **Onset:** Month _____ Year _____

Hospital/Clinic Name : _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

Illness: _____ **Onset:** Month _____ Year _____

Hospital/Clinic Name : _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

Illness: _____ **Onset:** Month _____ Year _____

Hospital/Clinic Name : _____ Phone: _____

Address: _____ City: _____ State _____ Zip _____

Date Last Seen: Month _____ Year _____

PRESCRIPTION MEDICATION

1. Medication: _____ Illness Prescribed for _____

2. Medication: _____ Illness Prescribed for _____

3. Medication: _____ Illness Prescribed for _____

4. Medication: _____ Illness Prescribed for _____

5. Medication: _____ Illness Prescribed for _____

6. Medication: _____ Illness Prescribed for _____

7. Medication: _____ Illness Prescribed for _____

8. Medication: _____ Illness Prescribed for _____

9. Medication: _____ Illness Prescribed for _____

10. Medication: _____ Illness Prescribed for _____

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Authorization To Obtain And Disclose Information

The terms that follow have the respective meanings when used in this Authorization:

Authorization: authorization to Obtain and Disclose information (2) Insurance Support Organizations: Medical Information Bureau, Inc

Medical Information Bureau, Inc. and/or Consumer Report Agency (3) Bureau: Medical Information Bureau

I understand that the life insurance companies named below, their reinsurance, 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, except the bureau, to give records or knowledge to CPS Insurance services or CPS/UNITED Insurance Services.

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 the information to update and improve my insurance program. Those parties names 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: (3) the Bureau: or (4) 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.

This Authorization will be valid for two years after the date it is signed. I understand that I or my authorized representative may request to receive a copy of this Authorization. I acknowledge receipt of the Notice to Proposed insured-Parts I and II.

Signed at _____ this ____ day of _____ Year _____

Signature of

Witness _____ Proposed Insured **X**

United Producers Inc.
CPS United Ins Services
CPS Insurance Services
CPS Settlements
American General Life
American Mayflower
American National
AXA/Equitable/MONY
Bankers Life of NY
Banner Life
Chase Insurance
Companion Life of NY

Fidelity Life Association
Genworth Financial
Guarantee Trust Life
Hartford Life
ING Companies
Illinois Mutual
Indianapolis Life
Jefferson Pilot
John Hancock
Life of the Southwest
Lincoln Benefit Life
Lincoln Financial

Mass Mutual
MetLife
MetLife Investors
Mutual of Omaha
Nationwide
New York Life
North American Life & Health
Old Mutual Financial Network
Phoenix Life
Presidential Life
Principal Financial
Protective Life

Prudential Financial
Reliastar Life
Sun Life Financial
Transamerica
United Home Life
United of Omaha
US Life
West Coast Life
Western & Southern Life
Western Reserve Life
William Penn

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 interview with your family, friends, neighbors, business associates, financial sources, 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 will be advised of the name and address and telephone number of the consumer reporting agency to whom 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 report by contacting the consumer reporting agency.

Medical Information Bureau (MIB) Inc. Disclosure Notice

Information regarding your insurability will be treated as confidential. The life insurance companies listed in the Notice or their reinsurer may, however, make a brief report thereon to the Medical Information Bureau, Inc., a nonprofit membership organization of life insurance companies, which operates an informational exchange bureau 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, upon request, will supply such company with such information it may have in its file.

Upon receipt of a request from you, 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 procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of the Bureau is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. The telephone is 617-426-3660.

The companies listed in this Notice, or their reinsurer, may also release information in their files to other life insurance companies to whom you may apply.

Office:
1100 East 6600 South, Suite 505
Salt Lake City, UT 84121

Patient Name: _____ Date of Birth: _____ / _____ / _____
mm dd yyyy

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to United Producers, Inc. (hereinafter referred to as The Company). 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 and 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, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that The Company may: 1) underwrite my preliminary inquiry for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have inquired for with The Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by providing written notification to The Company at the above address, Attention: George Varanakis. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me. I understand that any information that is disclosed pursuant to this Authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by The Company except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, The Company may not be able to process my preliminary inquiry. I understand that I or any authorized representative will receive a copy of this Authorization upon request.

Signature of Patient or Legal Representative

Relationship to Patient, if Legal Representative

Signature of Witness

Date