PLUS FINANCIAL NETWORK - **INFORMAL** APPLICATION

Date:____/____/____ Advisor Name: _____

Phone:_____ Email:_____

Personal Information - Proposed Insured:

Name:_____ Social Security #:_____

☐Male ☐Female Birthplace (State/Country):_____ Date Of Birth:____/____/____ Current Age:_____

Have You Ever Used Any Form Of Tobacco/Nicotine Products? ☐Yes ☐No If Yes, Date Of Last Use: ____/____/____

Type & Quantity Of Tobacco/Nicotine Products Used:_____

Driver's License: ☐Yes ☐No Number:_____ License State:_____

U.s. Citizenship: ☐Yes ☐No If No, Date Of Entry:____/____/____ Visa Type:_____ Exp:____/____/____

Address:_____ City:_____ State:____ Zip:_____

Home Phone:_____ Work Phone:_____ Email:_____

Employer:_____ Occupation:_____ Length Of Employment:_____

Employer Address:_____ City:_____ State:____ Zip:_____

Personal Earned Income:_____ Household Income: _____ Net Worth:_____

Current Height:_____ Current Weight: _____ Weight Loss in Last 12 Months: _____

New Coverage:

Face Amount:_____ Type of Coverage : ☐Term (10, 15, 20, 30) ☐WL ☐UL ☐VUL ☐LTC ☐DI

Purpose of Insurance: ☐Personal ☐Business - Keyperson ☐Business - Buy Sell ☐Business - Other

Non-Medical Questions:

1. Does the Proposed Insured intend to travel or reside outside the United States or Canada within the next two years? ☐YES ☐NO
   If yes, please list country, dates, length of stay and purpose._____

2. In the past five years, has the Proposed Insured participated in or does he/she intend to participate in any of the following: ☐YES ☐NO
   flights as a trainee, pilot or crew member; scuba diving; sky diving or parachuting; ultralight aviation; organized auto racing; cave exploration; hang gliding; organized boat racing; or mountaineering? If yes, please list the applicable activities._____
   _____

3. During the past 90 days, has the Proposed Insured submitted an application for life insurance to any company or begun the process of filling out an application? If yes, please list company name, amount applied for, purpose of insurance and if application will be placed._____ ☐YES ☐NO

4. Has the Proposed Insured ever had a life or disability insurance application modified, rated, declined, postponed withdrawn, cancelled or refused for renewal? If yes, please list date and reason._____ ☐YES ☐NO

5. Has the Proposed Insured ever filed for bankruptcy (personal or business)? ☐YES ☐NO
   If yes, please list chapter filed, date, reason and discharge date. _____
   _____

6. In the past five years, has the Proposed Insured been convicted of driving under the influence of alcohol or drugs, or been convicted of any driving violations? If yes, please list date, state, license number and specific violation._____ ☐YES ☐NO
   _____

7. Has the proposed insured ever been convicted of a criminal offense, felony or misdemeanor? If yes, please list date, state and charge._____ ☐YES ☐NO

Existing Coverage:

Policy Number	Insurance Company	Individual/ Group	Year Of Issue	Face Amount	For Personal or Business?	Replacement?	1035 Exchange?
						☐Yes ☐No	☐Yes ☐No
						☐Yes ☐No	☐Yes ☐No
						☐Yes ☐No	☐Yes ☐No

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Medical Questions:

1. Has the Proposed Insured ever been diagnosed as having, been treated, or consulted a licensed health care provider for:
   a. heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or any disorder of the heart? ☐YES ☐NO
   b. a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? ☐YES ☐NO
   c. cancer, tumors, masses, cysts or other such abnormalities? ☐YES ☐NO
   d. diabetes, a disorder of the thyroid or other glands or disorder of the immune system, blood or lymphatic system? ☐YES ☐NO
   e. colitis, hepatitis or a disorder of the asophagus, stomach, liver, pancreas, gall bladder or intestine? ☐YES ☐NO
   f. a disorder of the kidneys, bladder, prostate or reproductive orgrans or protein in the urine? ☐YES ☐NO
   g. asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorders? ☐YES ☐NO
   h. seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including anxiety, depression or other psychiatric conditions? ☐YES ☐NO
   i. arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐YES ☐NO
2. Have you been advised to have surgery or contemplated having a surgical operation? ☐YES ☐NO
3. Within the last 5 years, have you suffered from any disease(s) or received medical and/or surgical treatment for any condition not listed in Question 1? ☐YES ☐NO

If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone # of doctor; test performed; test results; medications or recommended treatment

_____

_____

_____

_____

_____

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_____

Current Medications:

Name Of Medication	Dosage	Name Of Medication	Dosage

Family History:

	Age If Living	Age At Death	Cardiac Conditions Or Heart Disease?		Cancer History?		Type
Father			☐ No	☐ Yes, Age At Onset_____	☐ No	☐ Yes, Age At Onset_____	
Mother			☐ No	☐ Yes, Age At Onset_____	☐ No	☐ Yes, Age At Onset_____	
Brother			☐ No	☐ Yes, Age At Onset_____	☐ No	☐ Yes, Age At Onset_____	
Sister			☐ No	☐ Yes, Age At Onset_____	☐ No	☐ Yes, Age At Onset_____	

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List all Physicians Seen in the Last 5 Years:

Primary Care Physician:

Name:_____ Phone:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Last Visit: _____ Reason for Visit: _____

Specialist #1:

Name:_____ Phone:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Last Visit: _____ Reason for Visit: _____

Specialist #2:

Name:_____ Phone:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Last Visit: _____ Reason for Visit: _____

Specialist #3:

Name:_____ Phone:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Last Visit: _____ Reason for Visit: _____

Additional Comments:

return via email to plusmarketing@pfnins.com or fax to 248.603.3595

PLUS Financial Network, 901 Wilshire Dr., Suite 140, Troy, MI 48084 • 800.887.7587 • fax 248.603.3595

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

HIPAA COMPLIANT

Mailing Address:
901 Wilshire Dr., Ste.140
Troy, MI 48084
Phone: (248) 356-7587

I understand that PLUS Financial Network, and its staff, the insurers PLUS Financial Network represents and their reinsurers, any insurance support organization and their authorized representatives may need to collect information about me in regard to obtaining insurance coverage.

Therefore, I authorize any physician, medical practitioner, medical examination company, hospital, clinic or other medical facility or medical-related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), Motor Vehicle Report (MVR), Prescription Drug Report (PDR), consumer reporting agency (CRA), or employer having information available as to the diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me to give the insurers listed below, their reinsurers and authorized representatives all such information. This information may include, but is not limited to, documents relating to my mental and physical health, office notes, laboratory studies, pathology reports, test results, mental health records, psychotherapy notes, drug/alcohol abuse, treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("information"). To facilitate rapid submission of such information, I authorize all said sources to give information and records to PLUS Financial Network, its staff and its authorized representatives.

I understand and agree that the information obtained by use of this Authorization will be used by PLUS Financial Network and/or insurers listed below and their authorized representatives to determine eligibility for insurance, and eligibility for benefits under existing policies. Any information obtained will not be released by PLUS Financial Network EXCEPT to one or more of the insurers listed below, their reinsurers, the MIB, my insurance agent or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize. I understand that the recipient of information disclosed pursuant to this Authorization may re-disclose the information and that, once disclosed, the information may no longer be protected by state or federal law.

I agree this Authorization shall be valid for two (2) years from the date shown below, unless I revoke it sooner, or in the event of a claim for benefits, for the duration of such claim. I understand that I have the right to revoke this Authorization in writing, mailed via certified mail, return receipt requested, to PLUS Financial Network at the mailing address provided above. I understand that a revocation is not effective to the extent that PLUS Financial Network or others have relied on the protected health information disclosed pursuant to this Authorization prior to its revocation.

I understand the execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand that my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the insurers listed below.

I acknowledge that I have read and understand the above and agree that this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were the original and can be relied upon by PLUS Financial Network and/or any third party designated herein.

PLUS Financial Network represents the following insurers: Accordia Life, Allstate, American General/AIG Companies, American Equity, American National, Ameritas, Assurity Life Insurance, Athene, AXA/Equitable, Banner Life, Chesapeake Life, Cincinnati Life, Fidelity Life, Fidelity Security Life, Genworth Life Insurance Company, Genworth Life & Annuity, Great American Life, Guarantee Trust Life, Guggenheim Life and Annuity, Hartford, Kemper, John Hancock Life, LifeSecure, Lincoln Benefit Life, Lincoln National Life, Mass Mutual, MetLife Investors, Metropolitan Life, Minnesota Life, Mutual of Omaha, National Guardian Life, National Life Group, National Western Life Insurance, Nationwide, North American Company for Life and Health, OneAmerica, Presidential, Principal, Principal National Life Insurance, Principal Life Insurance Company, Protective Life, Prudential Life/Pruco, SBLI, State Life, Sun Life of Canada, Symetra, Transamerica Life, Union Central Life, United Home Life, United of Omaha, Voya, Western National and Zurich.

Signed this_____ day of _____, 20_____

_____

Signature of Proposed Insured/Parent or Guardian Date of Birth

_____

Proposed Insured/Parent or Guardian *(Please Print)*

_____

Agent/Witness