

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:

- 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. _____
- 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. _____
- During the past 90 days, has the Proposed Insured submitted an application for life insurance to any company or YES NO
 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. _____
- Has the Proposed Insured ever had a life or disability insurance application modified, rated, declined, postponed YES NO
 withdrawn, cancelled or refused for renewal? If yes, please list date and reason. _____
- Has the Proposed Insured ever filed for bankruptcy (personal or business)? YES NO
 If yes, please list chapter filed, date, reason and discharge date. _____
- In the past five years, has the Proposed Insured been convicted of driving under the influence of alcohol or drugs, or YES NO
 been convicted of any driving violations? If yes, please list date, state, license number and specific violation. _____
- Has the proposed insured ever been convicted of a criminal offense, felony or misdemeanor? If yes, please list date, YES NO
 state and charge. _____

Existing Coverage:

Policy Number	Insurance Company	Individual/ Group	Year Of Issue	Face Amount	For Personal or Business?	Replacement?	1035 Exchange?
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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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:

v.3/12/15

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

**AUTHORIZATION TO OBTAIN
AND DISCLOSE INFORMATION**

HIPAA COMPLIANT

Mailing Address:
2155 Butterfield Dr., Ste. 102 South
Troy, MI 48084
Phone: (248) 356-7587
Fax: (248) 603-3595
www.pfnins.com

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



1/5/2017