CPS Reliable
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(800) 364-3110

Life Settlement Preliminary Inquiry

This form is used to gather information on a proposed insured's medical history and other factors that may impact the settlement of a life insurance policy.

Personal Information

Insured's Name* _____ Male ___ Female ___

Address _____ City _____ State _____ Zip _____

Daytime Phone Number _____ Evening Phone Number _____

Date of Birth _____ Age _____ Height _____ Weight _____ Soc. Sec. # _____

Occupation _____ Marital Status ___ Married ___ Single ___ Divorced ___ Widowed ___

Have you been party to a bankruptcy since this policy was issued? _____ No _____ Yes

Agent Information

Name _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Phone No. _____ Fax No. _____ E-mail _____

Life Insurance Policy Information

Insurance Company _____ Policy Number _____ Issue Date _____

Reason for Sale _____

Face Amount _____ Total Policy Loan _____ Cash Surrender Value _____

Annual Premium Amount _____ Date Next Premium Due _____

Policy State of Domicile: _____ Premium Mode _____ Annual _____ Semi-Annual _____ Quarterly _____ Monthly

Type of Policy: Term ____ UL ____ WL ____ SUL* ____SWL* ____ VUL ____ Term ____ Other (Please specify) _____

Policy Owner (if other than Insured) _____

Name of Trustee(s) (if owned by trust) or Officer (if owned by Company) _____

Date of Trust (if applicable) _____ Soc. Sec. # or Tax ID # _____ Daytime Phone Number _____

Trust Address _____ City _____ State _____ Zip _____

Name of Beneficiaries _____

Beneficiaries Address _____ City _____ State _____ Zip _____

Has there been a change in the beneficiaries? _____ No _____Yes (Please provide details: _____)

Are there any liens against the policy?_____ No _____Yes (Please provide details: _____)

* Please have other insured submit preliminary application if this is a survivorship policy.

Insured _____ Soc. Sec. # _____

Medical History (this section must be completed)

		Date	Illness
1.	Who is your primary care physician? When did you last consult him/her? Doctor's name, address, and phone number:		
2.	What other physicians have you consulted during the past five years?		
3.	In what hospitals, clinics, or other health facilities have you ever been treated?		

4. Please list all current medications:

Are you currently or have you ever been treated for any of the following conditions: (if yes, please complete separate CPS Quick Quote form)

- Cancer
- Depression
- Diabetes
- Heart attack or other heart condition(s)
- Hepatitis or elevated liver function
- Hypertension
- Kidney transplant
- Multiple Sclerosis
- Paralysis – Spinal Cord injury
- Parkinson's Disease
- Pulmonary Disease
- Rheumatoid Arthritis
- Sarcoidosis
- Sleep Apnea
- Stroke or Cerebrovascular accident
- Systemic Lupus Erythematosus
- Ulcerative Colitis – Crohn's Disease

Family History __ check here if this section is not applicable

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Yes No
If yes, please provide the following details:

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

Insured _____ Soc. Sec. # _____

Tobacco / Nicotine Usage

__ check here if this section is not applicable

1. Have you ever smoked cigarettes: Yes No If yes, date of last usage: _____ , _____

2. Have you used other tobacco or nicotine containing products: Yes ____ No ____

If yes, provide types and last date of use

_____

Drug and Alcohol Usage

__ check here if this section is not applicable

Do you currently drink alcohol? Yes No Date of last consumption: _____ Note amount below:		Did you ever drink substantially more than present? Yes No 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? Yes No

Have you ever sought medical treatment because of drug use or has drug use ever been a problem? Yes No

If yes, provide details:

Types of drug(s) used: _____

Date of last use: _____

Driving Record

__ check here if this section is not applicable

How many moving violations have you received in the past 3 years? _____

Have you ever been arrested for driving under the influence of alcohol or drugs? Yes No If yes, how many times? _____

Hazardous Activities

__ check here if this section is not applicable

Do you have a pilot's license? Yes No If yes, what type of certificate? Student Private Commercial ATP

If yes, do you have an instrument rating? Yes No

If yes, please indicate the number of hours flown:

	NON-COMMERCIAL	COMMERCIAL
Total time:	_____	_____
Last 12 months:	_____	_____
Contemplated in the next 12 months:	_____	_____

Have you ever participated in the following activities?

Scuba Diving Bungee Jumping Ultralight Flying Sky Diving

Mountain Climbing Hang Gliding Auto/Motorcycle Racing

If yes, please provide details: _____

_____

Required Documents and Illustrations

In addition to the information included in this preliminary inquiry, the following will need to be obtained in order to receive an offer:

1. If available, copy of the insurance policy or a copy of the face page
2. Inforce illustrations including:
    a. Universal Life: Solve for minimum premium payments for zero cash value at maturity
    b. Whole Life: Solve for vanishing premium
    c. Term Life: Current term illustration as well as an illustration on a converted permanent policy showing minimum premium payments for zero cash value at maturity.
    d. Additional illustrations might be necessary based upon provider requirements.
3. Medical records for the last five years. CPS Settlements can obtain records with signed HIPAA authorization.
4. Authorization to release medical records and policy information (HIPAA form, attached).
5. A copy of the bankruptcy discharge if the policyowner has been party to a bankruptcy since the policy was issued.
6. A copy of the divorce decree if the policyowner has ever been divorced.

Notice of Disclosure and Advice

1. Selling your life insurance policy is an important decision. You may have certain tax consequences resulting from the sale of your policy and should request assistance from a personal tax advisor.
2. The sale of your insurance policy may affect your right to receive government benefits or entitlements.
3. Provada Insurance Services, Inc. will only process your life insurance policy through licensed Providers/Purchasing Companies required as applicable.
4. There may be possible alternatives to selling your life insurance policy. This may include the option of an Accelerated Death Benefit offered by your insurance company. You are advised to consult a financial advisor, certified public accountant, or an attorney regarding these potential alternatives.
5. You will be informed, upon request, of the name, address, and phone number of the escrow agent that disburses your settlement proceeds. Further, you may inspect or receive copies of your escrow agreement for your settlement from the escrow agent.
6. Once you have received your proceeds from the sale of your life insurance policy, you may have a fifteen (15) day period in which to rescind the transaction. You are advised to refer to the purchasing contract supplied by the Provider/Purchaser Company of your life insurance policy regarding this matter.
7. Settlement proceeds could be subject to the claims of creditors.

Fraud Notice / Terms and Conditions

1. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, or files a statement of claim or an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and/or confinement in prison.
2. The applicant warrants and represents that all information contained in this preliminary inquiry is true and correct to the best of his or her knowledge.

_____ _____

Insured's Signature Date

_____ _____

Policy Owner's Signature Date

Authorization for Disclosure of Policy and Protected Health Information

HIPAA Compliant

Insured: _____

Date of Birth: _____ Social Security #: _____

The undersigned insured (hereafter referred to as "I", "me" or "my"), authorize the disclosure of my protected health information as defined under the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("PHI") as follows:

1. I hereby authorize any physician, medical practitioner, hospice, hospital, clinic, health care provider, or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person (each, an "Authorized Discloser") to provide Provada Insurance Services, Inc. and/or its authorized representatives (collectively, the "Authorized Recipient"), my life insurer, with any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, AIDS/HIV, drug or alcohol abuse, of or related to the insured.
2. This authorization allows for the disclosure, inspection, and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatments or hospitalization, including, but not limited to, all testing materials completed by or administered to the insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control. This authorization shall apply to any and all of the insured's health and medical records and information, whether or not personally identifiable or protected under any federal or state confidentiality or privacy laws or regulations.
3. Release of Policy Information. I understand that the information authorized for release may also include life insurance policy information, including but not limited to, applications, forms, riders and amendments concerning any life insurance policy under which my life is insured. I hereby authorize my insurance company to furnish Provada Insurance Services, Inc. with any information herein described above.
4. I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such PHI to complete a life settlement transaction or in order to sell a life settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my PHI made under this authorization. I understand that my PHI may be secured by a third-party provider and may be electronically transmitted to the Authorized Recipient, including transmission via web posting to a secure web site. I agree that a photocopy of this facsimile of this authorization shall be valid as the original.
5. I agree that this authorization shall remain valid for the life of the undersigned (or the last to survive of the undersigned if more than one signatory) or until the policy lapses without the possibility of reinstatement, whichever is earlier, absent any provisions of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under.
6. Right to Revoke Authorization: I acknowledge and understand that I may revoke this authorization any time with respect to any Authorized Discloser by notifying such Authorized Discloser in writing of my revocation of this authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized Discloser; provided, that, any revocation of this authorization shall not apply to the extent that the Authorized Discloser has taken action in reliance upon this authorization prior to receiving written notice of my revocation.
7. Inability to Condition Treatment, Payment, Enrollment, or Eligibility for Benefits on Provision of Authorization: I understand that this authorization is voluntary and I am not required to sign. No Authorized Discloser or other covered entity may condition my treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.

I understand that this authorization is not a consent or an authorization requested by a health care provider, health care clearinghouse or health plan covered by the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (the HIPAA Privacy Regulations"). I further understand that, as a result of this authorization, there is the potential for my PHI that is disclosed by any Authorized Discloser to an Authorized Recipient to be subject to redisclosure by the Authorized Recipient and my PHI that is disclosed to such Authorized Recipient may no longer be protected by the HIPAA Privacy Regulations.

I certify that I am executing and delivering this authorization freely and unilaterally as of the date written below. I further certify that this authorization is written in plain language and that I have retained a copy of this signed authorization for future reference.

Any person who knowingly and with the intent to defraud another, presents or causes to be presented any statement forming a part of, or in support of, an application for insurance or viatical settlement contract any false, incomplete or misleading information concerning any fact or thing material to the insurance policy or viatical settlement contract, or any claim thereunder, may commit a fraudulent viatical settlement act and may be subject to civil and criminal penalties.

Insured's Signature _____ Date _____

Name of Proposed Insured _____

Policy Owner's Signature (if other than insured) _____ Date _____

Name of Proposed Insured _____