CPI Companies Preliminary Application

What You Should Know

CPI Companies Life Brokerage is unique in its unwavering commitment to excellence in underwriting, design, implementation, and service. From our staff of experienced underwriters, to our advanced market design team, CPI Life Brokerage is always at the vanguard of best practices in the life insurance industry.
Medical underwriting is the single most important element in determining the cost structure for your life insurance. Our underwriting team are masters of every aspect of the underwriting process. From gathering the necessary records to discussing medical histories with attending physicians, we cover every angle.
CPI Companies acts as an advocate on YOUR behalf. We negotiate with all our insurance carriers to obtain the very best medical offers for you. CPI is contracted with over 20 well-rated life insurance carriers. Our goal is to identify the carrier who will underwrite you most aggressively while offering a competitive product. We recommend completing our short **Preliminary Application** before applying to any insurance company.

The Process & What to Expect

1. Complete preliminary application & sign Hipaa form
2. Medical info is gathered and reviewed to negotiate offers with insurance carriers (This is a detailed process and may require you to provide additional information. Our goal is to obtain realistic premium quotes)
3. Review negotiated premium quotes with Agent
4. Select insurance company and product for a formal application
5. Schedule the insurance exam (CPI will order this for you and a representative from the paramedical company will contact you)
6. Complete any other exams, interviews, or requirements needed for a final medical offer (Face amount and purpose of insurance dictate requirements)
7. Review final offer with Agent and approve policy to be issued
8. Policy is issued and reviewed for accuracy
9. Complete the requirements for policy delivery (sign final documents and pay premium)
10. Review your policy every 2-3 years

-LEAVE WITH CLIENT-

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Voorhees, NJ
www.cpicompanies.com
1.800.732.8062

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The Underwriting Specialists

PRELIMINARY APPLICATION

Please use (1) application per insured

Submitting Agent: ____

Personal Data *(required)*

Name of Insured: ____e-mail:____________________________________

( ) **Male** ( ) **Female** Date of Birth: ______________ SS#:______________________ Face Amount: __________________

Corp/Personal Owner: ________________ Beneficiary/Relationship: _________________ Citizenship: __________________

Replacement: ( ) **Yes** ( ) **No** Coverage Type*(check all that apply):* **Individual ( ) Survivorship ( ) / Term ( ) Permanent ( )**

Address:____

City/State/Zip:____

Phone:___________________________ Cell:_________________________ Best time to call:___________________________

Have you ever used tobacco or products containing nicotine (including, but not limited to, cigarettes, cigars, chewing tobacco, snuff, e-cigs, nicotine gum and/or patches)? *(If "Yes", list below.)* **Yes ( ) No ( )**

Type:	Date First Used:	Date Last Used:	Amount and Frequency:

Medical History *(required)*

Current Medications: ____

Personal Physician ____Phone _____________________________

Date & Reason Last Seen ____

Address ____

City/State/Zip ____

Name of other physicians and/or medical facilities that you have seen in the past (5) years (use additional paper if needed):

Physician Name ____Phone _______________________________

Date & Reason Last Seen ____

Address ____

City/State/Zip ____

Physician Name ____Phone ______________________________

Date & Reason Last Seen ____

Address ____

City/State/Zip ____

Preliminary Nonmedical & Medical Questionnaire

(to process your application more efficiently)

Name of Insured:____ **Date of Birth:**__________________________

Height:____ ft. _____ in. **Weight**: _______ lbs. If your weight has changed by over 10 lbs. in the last year, indicate amount and reason: ____ .

Family History:

	Age if Living & Current Health Status	Diabetes, Cancer, Stroke, Heart Disease? *(include age of onset)*	Age at Death & Cause
Father			
Mother			
Sibling(s)			

Personal History:

1. Have you ever been convicted of, or are you currently charged with, a felony or misdemeanor, or are you currently on parole or probation?

Yes ( ) No ( ) ____.

2. In the past 10 years, has your driver's license been suspended or revoked, been convicted of 2 or more moving violations or accidents, or have been convicted of, plead guilty or no contest to, driving while impaired, intoxicated, or under the influence of alcohol or drugs?

Yes ( ) No ( ) ____.

3. Do you hold a current pilot license, or have you in the past 5 years flown, or within the next 2 years do you intend to fly, other than as a passenger in any type of aircraft?

Yes ( ) No ( ) ____.

4. Have you in the past 2 years engaged in, or within the next 2 years do you intend to engage in, certain activities such as hang gliding, hot-air ballooning, ultra-light flying, heli-skiing, mountain, ice or rock climbing, cliff or base jumping, motor vehicle racing, motorcycle or any other motorized land or water vehicle racing, or scuba or sky diving?

Yes ( ) No ( ) ____.

5. Have you in the past 2 years traveled outside the U.S. or Canada, or changed your country of residence, or will you within the next 2 years travel outside the U.S. or Canada, or change your country of residence?

Yes ( ) No ( ) ____.

6. Have you ever had an application for life or health insurance declined, postponed, modified, rated or offered with a reduced face amount?

Yes ( ) No ( ) ____.

7. Have you ever been treated for drug or alcohol abuse or been advised by a licensed medical professional to limit your use of alcohol or any medication, prescribed or not?

Yes ( ) No ( ) ____.

8. Do you use alcoholic beverages? *(If "Yes", provide Type, Frequency & Amount.)*

Yes ( ) No ( ) ____.

9. Have you ever used or experimented with cocaine, marijuana, or other non-prescription stimulants, depressants, or narcotics?

Yes ( ) No ( ) ____.

10. Have you ever been diagnosed by a licensed medical professional as having AIDS Related Condition (ARC) or Acquired Immunodeficiency Syndrome (AIDS), or have you received treatment from a licensed medical professional for AIDS or ARC?

Yes ( ) No ( ) ____.

11. Have you ever filed for or declared bankruptcy? *(If yes, list chapter filed, date, reason and discharge date.)*

Yes ( ) No ( ) ____.

Name of Insured:____ **Date of Birth:**__________________________

12. Have you ever received care or treatment for, been advised by a medical professional, or consulted a health care provider regarding any of the following? *(If yes, please give details to include age at onset, diagnosis, treating physician's name, and type of treatment.)*

a. Hypertension, High Cholesterol, Chest Pain, Coronary Artery Disease, Heart Attack, Bypass Surgery, Angioplasty, Stent Placement, Heart Murmur/ Heart Valve Disease and/or Heart Valve Replacement, Cardiomyopathy, Congenital Heart Disease, Stroke/ mini-stroke (TIA), or aneurysm of any type?

Yes ( ) No ( ) ____.

b. Cancer of the Skin, Breast, Prostate, Melanoma, Lymphoma, or cancer of any internal organ or bones?

Yes ( ) No ( ) ____.

c. Diabetes, elevated blood sugar, thyroid, or other endocrine or glandular disorder?

Yes ( ) No ( ) ____ .

d. Chronic Lung Disease, COPD, Asthma, Sleep Apnea, Chronic Bronchitis, Emphysema, Tuberculosis, Sarcoidosis, Cystic Fibrosis or any other disorder of the respiratory system?

Yes ( ) No ( ) ____.

e. Anemia, leukemia, clotting disorder or any other blood disorder?

Yes ( ) No ( ) ____ .

f. Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or other disorder of the stomach, esophagus, liver, intestines, gallbladder, or pancreas?

Yes ( ) No ( ) ____.

g. Seizures, fainting, dizziness, epilepsy, stroke, paralysis or other neurologic or brain disorder?

Yes ( ) No ( ) ____.

h. Depression, ADD, OCD, Anxiety, Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Parkinson's, ALS, Demyelinating Disease including Multiple Sclerosis, Huntingdon's Disease, Quadriplegia, Paraplegia, Autism, or any other disorder of the brain or the central nervous system?

Yes ( ) No ( ) ____ .

i. Any complications of pregnancy or disorder of the testicles, prostate, breasts, ovaries, uterus, cervix, kidney or urinary bladder?

Yes ( ) No ( ) ____.

j. Arthritis, gout, or any disorder of the back, spine, muscles, nerves, bones, joints or skin?

Yes ( ) No ( ) ____.

k. Any disorder of the eyes, ears, nose or throat?

Yes ( ) No ( ) ____.

l. Any mental or physical disorder or medically or surgically treated condition not listed above?

Yes ( ) No ( ) ____.

13. In the last 5 years have you: *(If yes to any of the below, please provide details.)*

a. Had an electrocardiogram, x-ray, blood test, or other diagnostic test?
b. Had surgery or biopsy, or been an inpatient or outpatient in a hospital, clinic, or other medical or mental health facility?
c. Been advised by a member of the medical profession to have surgery, medical treatment, biopsy, or diagnostic testing that has not yet been completed?
d. Been referred to any other member of the medical profession or medical facility?

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HIPAA Compliant Authorization for Release of Information

(Required)

I (Patient/Insured) ________________________________authorize__________________________________ and/or any licensed physician, healthcare professional, hospital, clinic, laboratory, medical facility, pharmacy benefit manager, insurance company, motor vehicle agency, Medical Information Bureau (MIB), or any other organization, institution or person that has any records or knowledge of me or my health within the past 10 years, including my entire medical records, pharmaceutical records and any other information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to disclose such information, including my entire medical records and any other protected health information concerning me to Comprehensive Insurance Programs, Inc., 513 Centennial Blvd., Voorhees, NJ 08043, as well as the aforementioned life insurance companies and their reinsurers, when necessary, for the purpose of evaluating my insurability. 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 or 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, healthcare professional, hospital, clinic, medical facility or other healthcare provider to release and disclose my entire medical records without restriction. I understand that upon disclosure to any person or organization that is not a health plan or healthcare provider, the information may no longer be protected by federal privacy regulations.

This authorization shall remain in force for 36 months following the date of my signature below, *and that a photocopy or facsimile of this authorization has the full force and effect as the original.* I understand that I have the right to revoke this authorization in writing, at any time. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that a revocation does not apply to information that has already been released in response to this authorization.

I also acknowledge receipt of the notices required by the Fair Credit Reporting Act, which are printed below this authorization. I have been informed of my right to receive a copy of this authorization. I am aware I may be required to complete another application before coverage can be put into effect.

The Fair Credit Reporting Act Notification

In compliance with the Public Law 90-508 (Fair Credit Reporting Act), I understand that part of the underwriting procedure, any life insurance company may secure on me a routine inquiry involving interviews regarding my character, general reputation, personal characteristics, etc. I further understand that upon written request from me, additional information will be provided concerning the nature and scope of such inquiry, if one is actually made.

Patient/Insured Printed Name: ____DOB:______________________________

Patient/Insured Signature ____Date: ______________________________

Insurance Company Affiliations

AIG/American General Life Ins
Allianz
AXA Equitable
Banner Life Insurance Co.
Brighthouse Financial
Columbus Life
CPI Companies
Global Atlantic
Guardian
John Hancock
Lafayette Life Insurance Co.
Legal & General America
Lincoln Financial Group
Mass Mutual
MetLife
Minnesota Life
Mutual of Omaha
National Life Group
Nationwide Financial
New York Life
North American Company
Ohio National
Penn Mutual
Principal Life Insurance Co.
Principal National Life Insurance Co.
Protective Life
Prudential Insurance Co.
Safe Harbor
Symetra Life Insurance Co.
Transamerica Life Insurance
VOYA
Welcome Funds
William Penn Life
Zurich Life