

Kaiser Financial Group, Inc

Trial Application

Preliminary Inquiry by: _____ *NOT AN APPLICATION FOR LIFE INSURANCE*
 (Agent)

Insurance Information		
Face amount: _____	Plan type: <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> SUL	
Anticipated premium: _____		
Will this replace another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Total being replaced: _____ Premium being replaced: _____		
In-force Insurance Information		
Company	Date	Offer
_____	_____	_____
_____	_____	_____
_____	_____	_____
Will there be a 1035 exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No 1035 Amount: _____		
Applied For Insurance Information		
Have offers been made by other carriers? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Company	Date	Offer
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Information	
Insured #1	Insured #2
Name: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female	Name: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Date of Birth: _____	Date of Birth: _____
Social Security #: _____	Social Security #: _____
DL#: _____ State: _____	DL#: _____ State: _____
Have you smoked cigarettes in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you smoked cigarettes in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you used tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you used tobacco in any form? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Information

Insured #1	Insured #2																														
Personal physician: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date of last visit: _____ Reason: _____	Personal physician: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date of last visit: _____ Reason: _____																														
Other physicians/hospitals visited in the last 5 years	Other physicians/hospitals visited in the last 5 years																														
#1 Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date: _____ Reason: _____	#1 Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date: _____ Reason: _____																														
#2 Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date: _____ Reason: _____	#2 Name: _____ Address: _____ City/State/Zip: _____ Phone: _____ Date: _____ Reason: _____																														
Current Medications:	Current Medications:																														
Are you currently being, or have you ever been treated, for: (circle all that apply) <ul style="list-style-type: none"> • Cancer • Depression • Diabetes • Heart attack • Other cardiac issues • Hypertension • Kidney issues • Parkinson's Disease • Pulmonary Disease • Rheumatoid Arthritis • Stroke • Ulcerative colitis 	Are you currently being, or have you ever been treated, for: (circle all that apply) <ul style="list-style-type: none"> • Cancer • Depression • Diabetes • Heart attack • Other cardiac issues • Hypertension • Kidney issues • Parkinson's Disease • Pulmonary Disease • Rheumatoid Arthritis • Stroke • Ulcerative colitis 																														
Did any immediate family member die before age 60 due to heart disease or cancer? If so, please provide details below. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 25%; text-align: center;">Age at death</th> <th style="width: 60%; text-align: center;">Cause of death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Mother</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Brother</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sister</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Age at death	Cause of death	Father	_____	_____	Mother	_____	_____	Brother	_____	_____	Sister	_____	_____	Did any immediate family member die before age 60 due to heart disease or cancer? If so, please provide details below. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 25%; text-align: center;">Age at death</th> <th style="width: 60%; text-align: center;">Cause of death</th> </tr> </thead> <tbody> <tr> <td>Father</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Mother</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Brother</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Sister</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>		Age at death	Cause of death	Father	_____	_____	Mother	_____	_____	Brother	_____	_____	Sister	_____	_____
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Sister	_____	_____																													
Have you ever been asked to seek treatment for alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever been asked to seek treatment for alcohol or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No																														
Are you currently in AA or a similar program? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how often do you attend?	Are you currently in AA or a similar program? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, how often do you attend?																														
Do you currently drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate type and frequency.	Do you currently drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please indicate type and frequency.																														

In executing this form, the insured acknowledges and agrees that, subject to all applicable laws (including privacy laws), Kaiser Financial Group, Inc shall have the right to license, sell and assign all data and information submitted or collected in connection with this form, as well as all rights under the accompanying HIPAA Form authorizing the disclosure of the insured's protected health information, to a third party financial institution, which may use such data or information to: (a) track mortality trends; and (b) develop and use indices related to actual and anticipated longevity, mortality, life expectancies and/or similar measures of human lives in a manner in which the identity of underlying individuals may not be personally identified.

Signature _____

Print Name _____

Date _____

Kaiser Financial Group, Inc.

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Scotch Plains, NJ 07076-1768 Boca Raton, FL 33432-3999
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HIPAA Authorization for
Release of Health-Related
Information

Authorization to Release Information to the Following Companies:

- | | |
|---|--|
| American General Life Insurance Company | Minnesota Life |
| American National Insurance Company | Mony Life Insurance Company of America |
| AXA Equitable Life Insurance Company | MTL Insurance Company |
| Berkshire Life Insurance Company of America | North American Company for Life and Health Insurance |
| Columbian Mutual Life Insurance Company | Phoenix Life Insurance Company |
| EMSI Examination Management Services, Inc. | Presidential Life Insurance Company |
| Forethought Life Insurance Company | Prudential Financial |
| Genworth Life & Annuity Company Inc | Prudential Insurance Company of American |
| Genworth Life Insurance Company | ReliaStar Life Insurance Company |
| Guardian Insurance & Annuity Co Inc | Security Life of Denver Insurance Company |
| Guardian Life Insurance Company of America | Sun Life Assurance Company of Canada US |
| Hartford Life & Annuity Insurance Company | Transamerica Financial Life Insurance Company |
| John Hancock Life Insurance Company | Transamerica Life Insurance Company Family Markets |
| John Hancock Life Insurance Company USA | Transamerica Occidental Life Insurance Company |
| Lincoln National Life Insurance Company | US Life Insurance Company |
| MetLife Investors USA | West Coast Life Insurance Company |
| MetLife Insurance Company of CT | Other: _____ |

AUTHORIZATION TO OBTAIN INFORMATION:

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke and previous restrictions concerning access to such information:

- Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
- Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.
- The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Company and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its privacy notices. However, I also understand that any information disclosed under this authorization longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Company may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosure of my health information for the purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months from the date signed, regardless of my condition and whether living or deceased.
- By signing below, I agree to the terms of this authorization.

Signed at _____	This _____ Day of _____ 20 _____
Signature of Proposed Insured #1: _____	Signature of Proposed Insured #2: _____
Printed Name: _____	Printed Name: _____
Social Security Number: _____	Social Security Number: _____
DOB: _____	DOB: _____