THE PRODUCERS GROUP
9171 Towne Centre Drive #350
San Diego, CA 92122
Phone: 858-764-2988
Fax: 858-777-3596

Trial Application

PERSONAL INFORMATION	Proposed Insured 1	Proposed Insured 2 (If applicable)
Full Name		
Address		
Phone Number	( )	( )
Date of Birth	/ /	/ /
Male/Female	_____Male _____Female	_____Male _____Female
Social Security Number	- -	- -
Driver's License/State		
Occupation		
Do you Smoke?	_____Yes, what and how much? _____No, never smoked _____No, but quit _____	_____Yes, what and how much? _____No, never smoked _____No, but quit _____
Height/Weight	_____Ft._____In. _____Lbs.	_____Ft._____In. _____Lbs.
Name, address and phone number of personal or attending physician		
	( )	( )
Medications you currently take		

HEALTH QUESTIONNAIRE					
To your knowledge, have you ever had or experienced any of the following:		Insured 1		Insured 2	
		Yes	No	Yes	No
a	Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or other disease or disorder of the heart or arteries?				
b	Diabetes or disease of any gland?				
c	Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?				
d	Arthritis, gout, or any bone, joint, muscle or skin disorder?				
e	Asthma, bronchitis, pneumonia, emphysema, or any lung disorder?				
f	Cirrhosis, hepatitis, ulcer, colitis, diverticulitis or any disorder of the liver or intestines?				
g	Prostate or testicular disease, disease of the uterus, ovaries or breasts?				
h	Anemia, leukemia, clotting disorders, platelet disorders, infections or sources of blood loss?				

To your knowledge, have you ever had or experienced any of the following:		Insured 1		Insured 2	
		Yes	No	Yes	No
i	Cancer or tumors?				
j	An operation or admission to a health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance?				
k	Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?				
l	Any other health impairment or medically treated condition?				
m	Use of narcotics, amphetamines, cocaine or any prescription drug except in accordance with physician's instructions?				
n	Treatment for alcohol or drug use of been advised to have such treatment by a doctor, licensed practitioner or any organization?				
o	A positive test result for exposure to the HIV infection, or been diagnosed as having ARC or AIDS or other sickness derived from such infection?				
p	Have you been admitted to a medical facility in the last two years?				
q	Is there a family history of cancer, diabetes, heart disease, or has either parent died prior to age 60?				
r	In the last two years, have you been unable to work or been disabled for one month or more?				
s	Have you ever engaged in any type of flying as a pilot or crew member; skin, scuba, or sky diving; auto or boat racing; or any intention of doing so?				
t	Do you have any intention of traveling or residing outside the United States or Canada during the next two years?				
u	Has any application for insurance been declined, rated, modified or postponed?				
v	Do you have any life insurance currently in force, or will be replacing? (Please also disclose if you have any policy loans or plan to take a policy loan to fund the new insurance)				

Details for "Yes" answers to Health Questions Proposed Insured 1				
Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone # of Attending Doctor/Hospital

Details for "Yes" answers to Health Questions Proposed Insured 2				
Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone # of Attending Doctor/Hospital

FINANCIAL INFORMATION

Income Information

Salary: $ _____
Company pension: $ _____
Social Security: $ _____
Investment income: $ _____
IRA distribution: $ _____
Other: $ _____

Total income: $ _____
Living expenses: $ _____
Taxes (State & Federal) $ _____
Gifts to family: $ _____
Federal income tax bracket: _____
State income tax bracket: _____

Financial Information (Attach a financial statement if available)

Assets	Market Value	Cost Basis	Growth Assumption
Primary Home	$ _____	$ _____	_____%
Secondary Home	$ _____	$ _____	_____%
Real Estate	$ _____	$ _____	_____%
Business	$ _____	$ _____	_____%
Stocks	$ _____	$ _____	_____%
Mutual Funds	$ _____	$ _____	_____%
Annuities	$ _____	$ _____	_____%
Tax Free Bonds	$ _____	$ _____	_____%
Money Markets	$ _____	$ _____	_____%
Retirement Plans	$ _____	$ _____	_____%
Notes Receivable	$ _____	$ _____	_____%
Other	$ _____	$ _____	_____%

Total Assets: $ _____

Less Liabilities: $ _____

Net Worth: $ _____

Plus Personally Owned Life Ins.: $ _____

Taxable Estate: $ _____

Do you anticipate any inheritances? " No "Yes, estimated amount: $ _____

Requested Plan of Insurance	
Type of Insurance Desired:	☐ Universal Life ☐ Whole Life ☐ Term ☐ Survivorship ☐ Variable ☐ Other:_____
Insurance currently pending or applied for with all carriers: CARRIER AMOUNT TYPE STATUS _____ _____	
Total Death Benefit to be placed:	$
Desired Premium:	$
Additional Dump In: Source of Funds:	$

Concept Information: (Purpose of the Insurance)	
Personal	Business
☐ Estate Planning ☐ Charitable Contribution ☐ Wealth Replacement ☐ Income Replacement ☐ Loan Securement Amount of Loan: $_____ ☐ Other:_____	☐ Buy/Sell ☐ Keyperson ☐ Business Continuation ☐ Loan Securement Amount of Loan: $_____ ☐ Other:_____ Business Ownership %:_____ Gross Sales/Revenue: $_____ Expenses: $_____ Book Value of Company: $_____
How was the amount of insurance calculated:	

Agent Information	
Agent Name	
Agent Contact	
Address	
Phone Number	( )
Fax Number	( )
E-mail Address	
Social Security Number	

Notes and Special Consideration:

Case Manager: _____

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AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

This authorization complies with the HIPAA Privacy Rule

I understand that the companies listed below, their reinsurers, any insurance support organizations, the authorized representatives of these companies and Freundt & Associates Insurance Services Inc., DBA The Producers Group may need to collect information on me in regard to proposed insurance coverage. I understand the information collected will be used to determine eligibility and risk rating for insurance, claims or to aide in updating and improving my insurance program.

Therefore, I authorize any physician, medical practitioner, health care provider, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical or medically related facility, insurance or reinsurance companies, the Medical Information Bureau, Inc., consumer reporting agency, financial sources, employers and any institution or person that has provided payment, treatment, or other services to me or on my behalf within the past 20 years to disclose to the companies named below the types of information specified in this Authorization upon presentation of this Authorization or a photocopy. To facilitate such information, I authorize all said sources, except the Medical Information Bureau, Inc., to provide such records or knowledge to Freundt & Associates Insurance Services, Inc., The Producers Group.

I understand that any agreements I have made to restrict the information named below, including protected health information, do not apply to this Authorization. I instruct and authorize the release and disclosure of my information, including my entire medical record without restriction including past and present physical and mental state of health, information on the treatment of Human Immunodeficiency Virus (HIV), AIDS, infection and sexually transmitted diseases, drug and/or alcohol use, diagnosis or treatment of mental illness, records or facts related to employment, other insurance coverage, character habits, avocations, finances, reputation, credit, or other personal traits.

I understand any protected health information collected may be disclosed to other insurance companies to which I have applied or may apply, reinsurance companies, the Medical Information Bureau, Inc., or other persons or organizations performing business, professional or insurance functions for the companies named below, or as may be otherwise legally allowed. I further understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person may disclose it to another party, at which time it may no longer be protected by federal privacy and confidentiality laws.

I understand this Authorization may be valid for two years after the date of signing and a copy of this Authorization is as good as the original. I understand that I may request to receive a copy of this Authorization.

I understand that if I alter or refuse to sign this authorization to release my complete medical records, the insurance companies named below may not be able to process my application. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment).

NOTICE TO PROPOSED INSURED

In connection with your inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics and mode of living. Upon written request to the life insurance companies listed below, you will be informed whether or not an investigative consumer report was requested, and, if so, you will be advised of the name and address of the consumer reporting agency to which the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect a copy of any such report by contacting the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed below or their reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Telephone (617) 426-3660.

The companies listed below or their reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the companies listed below will rely heavily on information provided by you. The companies may also seek information, from others, such as medical professionals who have treated you.

In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization.

You have the right to be told about, and to see a copy, if you wish, of items of personal information about you which appear in the insurance companies files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

I acknowledge receipt of the Notice to Proposed Insured and Notice of Information Practices.

COMPANIES

Acacia Life
Accordia Life & Annuity, A Global Atlantic Company
American Equity
American General
American General Life & Accident
American National
Americo Financial Life and Annuity Insurance Company
Ameritas Life
Assurity Life
Athene
AXA Financial
Banner Life
Centrian Life
Companion Life
Examination Mgmt Services, Inc.
Fidelity & Guarantee Life Insurance Company
Fidelity & Guarantee Life Insurance Company of NY
First Symetra National Life Insurance Company of NY
Foresters
Freundt & Assoc Insurance Services, Inc.
General Re Life Corp
Genworth Life Insurance Company
Genworth Life of NY
Great American Life
Guardian Life
John Hancock
Life of the Southwest
Life Secure
Lincoln National Life Insurance Company
Lloyds of London
Mass Mutual
MetLife Insurance Company USA
Metropolitan Life Insurance Company
Minnesota Life
Mutual of Omaha
National Life Insurance Company
National Western Life
Nationwide Life
New York Life
North American Company
Pan-American Assurance Company International, Inc.
Penn Mutual Life Insurance Company
Principal Life Ins Company
Principal National Life Insurance Company
Protective Life
Protective Life & Annuity NY
Prudential
Reliastar Life Insurance Company
Reliastar Life Ins Company of NY
SBLI
Securian Life
Security Life of Denver
Security Mutual Life of NY
Standard Insurance Company
State Life/One America
Symetra
The Standard Life Ins Company of NY
Transamerica Life Insurance Company
Transamerica Financial Life Insurance
Union Central
United of Omaha
United States Life Insurance Company in the City of NY
VOYA Insurance & Annuity Company
William Penn
Zurich American Life Insurance Company
Zurich American Life Insurance Company of NY

If you would like to receive a more detailed explanation of a company's information practices or if you would like to revoke this authorization, please send your request in writing to:
The Producers Group, affiliate of Freundt and Associates Insurance Services, Inc.
Attn: Privacy Official.

Signed at_____ Date_____

X_____
(Signature of Proposed Insured)

_____
Name Proposed Insured (please print)