

CWAAdvisor
Services

Informal Application

Form IA

Built by producers, for producers.™

Full Name:	Sex:	DOB:	Date of Last Nicotine Use: Specify tobacco: Using nicotine gum or patch?
Place of Birth	Height:	Weight:	SS#: Dr. Lic #
Address:			
City	State:	Zip:	
Insurance Amount:	Plan of Insurance:		

Primary Care Physician:	Address/ Phone Number:	Date Last Seen:	Reason:
Additional physicians, specialists, or institutions? <i>Please supply additional sheet if necessary. (i.e. Cardiologist, Urologist, Dermatologist, Oncologist, Psychiatrist, Hospitals, or Clinics?)</i>			

Medical History - Please supply details of "Yes" answers below to include date of first diagnosis, name and address of doctor, test performed, test results, medication(s) or recommended treatment in the area provided.

Has the proposed Insured ever been diagnosed as having, been treated for, or consulted a licenses health care provider for:

	YES	NO
a) Heart disease, heart attack, chest pain, irregular heartbeat, murmur, high cholesterol, high blood pressure, or other disorder of the heart?	<input type="checkbox"/>	<input type="checkbox"/>
b) Blood clot, aneurysm, stroke, or other disease, disorder, or blockage of the arteries or veins?	<input type="checkbox"/>	<input type="checkbox"/>
c) Cancer, tumors, masses, cysts, or other such abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
d) Diabetes, elevated blood sugars, glucose intolerance, or disease of any gland?	<input type="checkbox"/>	<input type="checkbox"/>
e) Colitis, hepatitis, or a disorder of the esophagus, stomach, liver, pancreas, gall bladder, or intestine?	<input type="checkbox"/>	<input type="checkbox"/>
f) Disorder of the kidneys, bladder, prostate, or reproductive organs, or sugar or protein in the urine?	<input type="checkbox"/>	<input type="checkbox"/>
g) Asthma, bronchitis, emphysema, sleep apnea, or other breathing or lung disorder?	<input type="checkbox"/>	<input type="checkbox"/>
h) Seizures, a disorder of the brain or spinal cord, or other nervous system abnormality including a mental or nervous disorder?	<input type="checkbox"/>	<input type="checkbox"/>
i) Arthritis, muscle disorders, connective tissue disease or other bone or joint disorders?	<input type="checkbox"/>	<input type="checkbox"/>
j) MALES: Prostate or testicular, or FEMALES: Uterine, cervix, ovary, or breast disease?	<input type="checkbox"/>	<input type="checkbox"/>
k) Any hospital admission, surgery, or EMERGENCY ROOM visit or outpatient surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Details of "YES" answers: (Please attach additional page if necessary):

Prescription and Over the Counter Drugs: (List all medications, including over-the-counter drugs and vitamins):

Financial Information:

Total amt. of insurance coverage in-force: _____ Current Net Worth: _____

Family History: Have any immediate family members (parents, brothers, sisters) died prior to age 60?

YES NO

If "YES," identify family member(s), cause of death, and age at death _____

Special Risk: Avocation or special risk concerns: (flying, diving, planned foreign travel, etc...)

YES NO

If "YES," you will need to submit the appropriate underwriting questionnaire which can be found at www.cwaas.com or call 239-434-7434

Agent's Report:

Submitted By:	Agency:	
Phone #:	Fax #:	E-Mail Address:

AUTHORIZATION TO OBTAIN AND DISCLOSE CONFIDENTIAL MEDICAL INFORMATION

Proposed Insured:	Sex:	DOB:	SS#:
-------------------	------	------	------

Records and Information obtained from the proposed insured or other parties may be disclosed to and between the insurance companies and/or the insurance agencies listed below, CWA Advisor Services, LLC, Capital Wealth Advisors, Inc, and brokers, contractors, employees, representatives, and agents working for or through CWA Advisor Services, LLC and Capital Wealth Advisors, Inc. for the purposes of the proposed insured applying for or evaluating life insurance coverage.

Insurers and Agencies

21st Service AIG Allianz American General Life Insurance Company American National (ANICO) APPS Paramedical Aviva AVS AXA Equitable Banner Life Brokers Alliance Capital Settlements Capital Wealth Advisors Columbus Life Crump Life Insurance Services, Inc. Cundy, Inc. CWA Advisor Services EMO EMSI Fasano Associates, Inc. Fidelity & Guaranty Life Insurance Co. Genworth Life Insurance Company	Global Financial Advisory Guardian Hartford Life and Annuity Insurance Co. Indianapolis Life ING-Reliastar Life Insurance Companies ING-Security Life of Denver Companies Jackson National John Hancock Life Insurance Companies Lewis & Ellis, Inc. Liberty Life Assurance Co. of Boston Life Insurance Co. of the Southwest Lincoln Benefit Life Company Lincoln Financial Companies Mass Mutual Mediconnect Metropolitan Life Insurance Company Minnesota Life National Life Insurance Company Nationwide Financial New England Life Insurance Company New York Life Insurance & Annuity Co. North American Company	Ohio National Pacific Life and Annuity Company Pacific Life Insurance Company Penn Mutual Phoenix Life Insurance Company Portamedic Protective Life Prudential Life Insurance Companies RSA Medical Security Mutual South Cap State Life Insurance Company Sun Financial Sun Life Assurance Company of Canada Sun Life Insurance Company of America TransAmerica Life Insurance Union Central Life United of Omaha US Life Insurance Company West Coast Life World Wide Inspections.
--	---	--

Per HIPAA regulations, the purpose of this Authorization is to determine my eligibility and assist in placement of my application for insurance products and services from the life insurance companies listed above. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I hereby authorize any medical practitioner, any medical facility; and laboratory; any other medical entity; any insurer; any financial institution; my employer; and any consumer reporting agency to give the information described above to the companies listed above.

Those parties named above may disclose the information that they have collected about me for the purposes referenced herein only. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; or (3) other persons who perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use secured internet-based systems ("UConnect", "Paperclip" & "FileShare" to store / access some or all of the confidential and personal information.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to the re-disclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. Unless otherwise revoked, I agree this Authorization shall remain valid for 24 months from the date of my signature below. I understand that I may refuse to sign this authorization but that if I do refuse to sign, the companies listed above may not be able to fulfill the purpose of this authorization. I understand that I may revoke this authorization at any time by writing to 787 5th Ave S, Naples, FL 34102; however, any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

A photocopy of this Authorization is valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s).

I, the undersigned hereby authorize any and all medical practitioners, physicians, hospitals, clinics and custodians or anyone else located at:

Medical Facility: _____
Facility Address: _____
Date of Services: _____
Contact Person: _____

To release records and information regarding the Proposed Insured listed above to and exchanged between the parties listed above and:

Requestor of Medical Information: _____
Company/Agency/Firm: _____
Company/Agency/Firm Address: _____
Contact Person Information: _____

Signed at _____ this _____ day of _____, (year) _____.

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative:

X _____

If signed by Authorized Representative of Proposed Insured, describe authority or relationship to proposed insured (e.g. parent of minor child, guardian, conservator, etc.)

Signature of Witness: _____ Signature of Policy Owner(s) (not required): _____

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child: _____ *Relationship of Representative to Minor:* _____

Every Physician visit going forward will be needed to properly evaluate your life insurance risk. PLEASE notify your agent IMMEDIATELY of any additional visits to doctors or hospitals after signing this form. Thank you.

Instructions to Agent: A copy of the notification appearing below must be given to the proposed insured at the time of signature.

Notice to Proposed Insured

Federal Fair Credit Reporting Act

In connection with your informal 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 in this Notice, within reasonable time after receipt of the Notice, you will be informed whether or not an investigative consumer report was requested. If so, you will be advised of the name, address and telephone number 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 and to receive a copy of any such report by contacting the consumer reporting agency.

MIB (Medical Information Bureau) Disclosure

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their re-insurers may however make a brief report thereon to the Medical Information Bureau, Inc. This is a non-profit membership 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 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 this 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 in accordance 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 02122 Tel. (617) 426-3660.

The companies listed in this Notice or their re-insurers may also release information in their files to the other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely primarily on information provided by you. The companies may also seek information from others, such as medical professions who have treated you. In some cases, the insurance companies may ask a consumer reporting agency to collect information and submit an investigative consumer report to them as explained in this Notice under Federal Fair Credit Reporting Act. You may request to be interviewed in connection with the preparation of this report. In Certain Limited situations, the insurance companies are allowed by law to disclose necessary items of personal information to third parties without your specific authorization.

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

The above is a general description of the listed insurance companies, and your agent's information practices. If you would like to receive a more detailed explanation of these practices, please send your requests to: CWA Advisor Services, LLC Attn: Underwriting Department Supervisor, 787 5th Ave S, Naples, FL 34102.

CWA Advisor Services / Capital Wealth Advisors acts as General Agent for the following listed insurance companies:

AIG Life Insurance Company	ING - Reliastar	Phoenix Home Life
Allianz	John Hancock Financial Services	Principal Life
American General Life Insurance Companies	Life Insurance Company of the Southwest	Protective Life Insurance Company
American General Life Insurance Company of NY	Lincoln Benefit Life Insurance Company	Prudential Life Insurance Company
American National (ANICO)	Lincoln Life Insurance Company	Security Connecticut
AmerUS Life Insurance Company	Metropolitan Life Insurance Company	Security Life of Denver Insurance Company
Aviva	Minnesota Life	Security Mutual Life Insurance Company
AXA Equitalbe	National Life of Vermont	Sun Life Financial
Banner Life	Nationwide Life Insurance Company	Transamerica
F&G Life	North American Company for Life and Health	Union Central
Genworth Life Insurance Company	Ohio National	United of Omaha Life Insurance Company
Hartford Life Insurance Company	Pacific Life	United States Life Insurance Company
Indianapolis Life Insurance Company	Penn Mutual	in the City of New York

CWA

Advisor
Services

Doctor List Form

Form
H-DL-1

Built by producers, for producers.™

Please provide the names, specialty, address, and telephone numbers of all medical doctors you have seen over the past 5 years.

Client Name: _____ SS#: _____ DOB: _____

Doctor #1	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #2	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #3	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #4	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #5	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #6	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #7	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____

Doctor #8	
Name:	_____
Address:	_____ _____
Type of Doctor:	_____
Phone Number:	_____
Contact Person:	_____