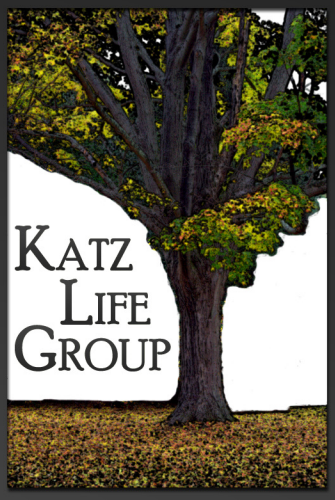

Life Insurance Preliminary Application

Clear Results For Life™

Katz Life Group, LLC
5350 Poplar Avenue, Suite 550
Memphis, TN 38119
info@katzlife.com
(877) 763-0098

Life Insurance Preliminary Application

Please complete all fields.

Unsure how to fill something out? Our representatives are here to help. Call now: (877) 763-0098

Insured Name _____

SS# _____-_____-_____ Insured Date of Birth_____/_____/___

Address_____

City_____ State_____ Zip_____County_____

Phone Number: (____)_____-_____ Email Address: _____

Height:_____Weight:_____ Sex: ☐ Male ☐ Female Tobacco Use: ☐ Yes ☐ No

Place of Birth: City_____ State_____ Country_____

Insurance Required: $_____ Net Worth: $_____ Real Estate (%) _____

Insurance In Force: $_____ With Which Carriers? _____

Adjusted Gross Income (AGI) _____ Federal Income Tax Bracket (%) _____

Do you intend to take out a loan for this insurance? ☐ Yes ☐ No If No, please skip the next section.

What do you intend to use as Collateral for your loan? Please check all that apply.

☐ Real Estate ☐ Marketable Securities ☐ Life Insurance Policy Cash Values

☐ Cash/CD/Treasury ☐ Concentrated Stock Positions ☐ Art/Yacht/Airplaine

☐ Life Insurance Policy ☐ Accounts Receivable ☐ Personal Guarantee

☐ Other (Please explain below on Page 7)

Please note that the interest rate will be either Prime or LIBOR based and will depend on the strength of the underlying collateral.

Please attach a balance sheet generated by the client's advisor to this application. This will be necessary to develop a personalized structured life financing proposal.

Life Insurance Preliminary Application

Medical History of Insured:

Please give a brief description of your medical condtion: _____

_____

_____

Physician Information:

Primary Care Physician _____ Phone Number (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Date _____/_____/_____ Reason for Visit _____

Other Physician (1)_____ Phone Number (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Date _____/_____/_____ Reason for Visit _____

Other Physician (2)_____ Phone Number (_____)_____-_____

Address_____ City_____ State_____ Zip_____

Date _____/_____/_____ Reason for Visit _____

Any Medication(s)_____

_____

_____

You may attach an additional page for more physician information.

Do you currently drink alcohol? ☐ Yes ☐ No Date of last consumption: _____

Type consumed: _____ Amount Per Week: _____

Have you ever consulted a doctor or received treatment because of your alcohol use? ☐ Yes ☐ No

Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No

If yes, provide dates: _____

Miscellaneous Information:

Foreign Travel (frequency/length/purpose): _____

Avocation & Aviation (for pilots & student pilots only) Details

Date of last flight/aircraft type: _____ Number of flights next 12 months _____

Do you engage in any of the following pursuits? Please check any appropriate boxes and add an explanation below.

☐ Scuba Diving ☐ Sky Diving ☐ Parachuting ☐ Other (specify) _____

☐ Hang Gliding ☐ Ballooning ☐ Racing (Motor-Vehicle Type)

Life Insurance Preliminary Application

Client Protection First Life™

Medical History of Insured (page 2):

Please attach any and all APS's.

Coronary History

Date of diagnosis or first chest pain: _____

Date/Details of treatment/surgery: _____

_____

_____

Date of last stress EKG: _____/_____/_____ Results: _____

By Whom: _____ Any pain since treatment/surgery: ☐ Yes ☐ No

Cancer History

Exact name and location of cancer: _____

Stage and Grade: _____

Who would have the pathology report? _____

_____

Dates/Details of treatment/surgery: _____

Diabetes History

Date of Diagnosis: _____/_____/_____ Treatment (check one) ☐ Diet Only ☐ Oral Medication ☐ Insulin

Details: _____

Do you regularly test your blood glucose? ☐ Yes ☐ No Results: _____

Frequency: _____

Latest result of glycohemoglobin (AIC) test: _____ % Date: _____/_____/_____

Have you been diagnosed with having protein and/or micralbumin in your urine: ☐ Yes ☐ No

Have you ever had:

Any eye trouble:	☐ Yes ☐ No	Kidney trouble:	☐ Yes ☐ No	Heart trouble:	☐ Yes ☐ No
Neuritis/Neuralgia:	☐ Yes ☐ No	High Blood Pressure:	☐ Yes ☐ No	Insulin reactions:	☐ Yes ☐ No

Life Insurance Preliminary Application

Clear Results For Life™

Agents Report

Submitted By _____

What is the insurance need for this case? _____

_____

_____

If aloan or premium financing is to be used, please briefly describe the loan payoff strategy discussed with the Client. _____

_____

_____

_____

If this case has been previously submitted, please list the carriers submitted to: _____

_____

_____

I confirm that all of the information provided in this premium finance application is true and accurate:

_____ _____

Signed Date

_____

Relationship or Authority of Personal Representative (if applicable)

How did you hear about the Katz Life Group?

☐ Referral ☐ Google ☐ Yahoo ☐ WebSite/Blog ☐ Other _____

Life Insurance Preliminary Application

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations and the authorized representatives of these companies may need to collect information on me in regard to proposed life insurance coverage.

Therefore, I authorize any licensed physician, medical practitioner, hospital, clinic or any other medically related facility, Medical Information Bureau (MIB), or other organization, institution or person that has any records or knowledge of the proposed insured to furnish to the insurance companies named below the types of information specified in this Authorization.

The types of information will include records or facts related to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, reputation, credit, or other personal traits.

The information will be used by the insurance companies named below and/or their reinsurers to determine eligibility for insurance and claims. The information may also be used by the insurance agent to aid in updating and improving my insurance program.

The information collected may be disclosed to other insurance companies to which I have applied or may apply to reinsurance companies, the Medical Bureau, Inc., or other persons or organizations performing business, professional or insurance functions for the insurance companies named below, or as may be otherwise legally allowed.

This Authorization may be valid for two years after the date of signing. I acknowledge receipt of the Notice to Proposed insured and Notice of Information Practices.

INSTRUCTION TO AGENT:

THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

AIG	First Colony	LEFS	Newstream	Riversource
American General	Genworth	Lincoln Benefit Life	Pacific Life	Sec. Life of Denver
American National	Hartford	Lincoln Financial Group	Phoenix Life	Sun Life Of Canada
Allianz	Indianapolis Life	Mass Mutual	Producer's Edge	Total Financial
AXA/Equitable	ING/ Reliastar	Metropolitan Life	Protective	TransAmerica
Aviva	Inscap/ Concord Capital	Midland	Protective	Travelers
Banner Life	Insurance Designers, LLC	Mutual of Omaha	Principal	United of Omaha
Fidelity & Guarantee	John Hancock	New York Life	Prudential	West Coast Life
Finance For Life	Katz Life Group, LLC			

Signed at _____ this _____ day of _____ 20 _____

Signature of Proposed Insured _____

NOTICE TO PROPOSED INSURED

In compliance with Public Law 90-508 (Fair Credit Reporting Act), I understand that as part of the underwriting procedure, any of the insurance companies listed may secure on me a routine inquiry involving interviews with third parties such as family members, business associates, financial sources, friends, or others who may have information concerning my character, general reputation, personal characteristics and mode of living. I further understand that upon written request from me, additional information will be provided me concerning the nature and scope of the inquiry if one is actually made.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice 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.

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.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administrating your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The Companies may also seek information, from others, such as medical professionals who have treated you, hospitals, other insurance companies, consumer reporting agencies, or the Medical Information Bureau, Inc. (MIB).

In certain circumstances, 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 our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal 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 REQUEST TO THE KATZ LIFE GROUP, LLC

Life Insurance Preliminary Application

Health Insurance Portability and Accountability ACT (HIPAA)
HIPAA Authorization

_____ _____/_____/_____

Name of Proposed Insured/Patient | Date of Birth

I hereby authorize each physician, doctor, physician practice group, nurse, pharmacy, hospital, clinic and/or any other health care provider identified below (each, an "Authorized Discloser") to provide Katz Life Group, LLC and/or any of its affiliates, directors, officers, employees, agents, independent contractors, service providers or other authorized representatives, and all information and/or records as to diagnosis, treatment and/or prognosis (including any and all dates thereof) concerning my past present or future physical or mental history or condition. I also specifically authorize each Authorized Discloser to release to Katz Life Group, LLC or their associate or affiliate companies the results of any HIV or AIDS test as well as any other information relating to sexually transmitted diseases, drug or alcohol abuse and psychiatric evaluations and/or information.

I understand that all medical information disclosed hereunder will be treated as confidential and will only be used by Katz Life Group, LLC & or its associate or affiliate companies in connection with its decision to purchase and/or maintain one or more life insurance policies under which my life is insured. I further understand that I am not required to sign this Authorization in order to obtain health care benefits (treatment, payment or enrollment).

I hereby authorize my insurance company to furnish Katz Life Group, LLC or its associate of affiliate companies with any information or forms in connection with any life insurance policy and under which my life is insured (including any conversions thereof or replacements therefore).

I acknowledge and understand that I may revoke this Authorization at any time with respect to any Authorized Disclosure by notifying such Authorized Discloser of my revocation of this Authorization in writing and delivering my revocation by mail or personal delivery at such address designated by such Authorized Discloser; provided, that, any revocation of this Authorization shall not apply to the extent that (i) the Authorized Discloser has taken action in reliance upon this Authorization prior to receiving notice of my revocation or (ii), if this Authorization was obtained as a condition of obtaining insurance coverage, other law provides an insurer with the right to contest a claim under an insurance policy.

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, and of my medical information disclosed by any Authorized Discloser to Katz Life Group, LLC may be re-disclosed by Katz Life Group, LLC or their associate of affiliate companies and 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 and that all information contained in this Authorization is true and correct. I further certify that this Authorization is written in plain language and I fully understand its contents. I will retain a copy of this signed Authorization for future reference.

I specifically authorize and request my insurance company and each Authorized Discloser to rely upon a photo static or facsimile copy or other reproduction of this Authorization.

This Authorization shall remain valid until, and shall expire on, the date one year following the date of my death.

_____	_____	_____
NAME OF INSURED	SIGNATURE OF INSURED	DATE
_____	_____	_____
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE
_____	_____	_____
NAME OF OWNER (if other than Insured)	SIGNATURE OF OWNER (If other than Insured)	DATE
_____	_____	_____
NAME OF WITNESS	SIGNATURE OF WITNESS	DATE

LIFE INSURANCE PRELIMINARY APPLICATION

CLEAR RESULTS FOR LIFE™

CASE NOTES & SPECIAL INSTRUCTIONS

5350 Poplar Avenue, Suite 550, Memphis, TN 38119
Phone 901.763.0098 Toll Free 877.763.0098

SEND CASES TO > cases@katzlife.com or fax to 901.763.0058