INFORMAL APPLICATION PROCESS

WHEN MIGHT AN INFORMAL APPLICATION BE CONSIDERED?

- Concerns related to carrier capacity (i.e., reinsurance required due to face amount)
- Larger face amount (Premium threshold: $25,000+) and impaired risk and multiple carriers offer the desired product
- The client is ready to proceed with a formal application within the next 2-3 months

STEP-BY-STEP GUIDE

Discuss the prospective case with your regional consultant to develop the case design

Confirm client's desire to proceed

Complete the informal application including The Cason Group HIPAA form.

Submit the application packet and illustration to lifenewbusiness@thecasongroup.com. Any additional information you feel is important to the case can be submitted as a cover letter as well.

Your case manager will confirm when the case is set up and ask for any initial details needed from you and your client if applicable.

If you are ordering the exam, please provide all exam documents including the lab slip once received. Otherwise, your case manager will order the exam if one is being completed. It can also expedite the process if your client provides the lab results available on the exam company website. ** Please remember to advise your client to fast prior to the lab draw.**

Our underwriting team will review the application and determine if any additional information is needed and where to request medical records.

- Additional information regarding potential underwriting risks may be requested during the underwriting review
- Our team typically orders the records unless otherwise specified
- Some medical facilities require special authorizations in addition to our HIPAA form
- Receiving medical records on average can take between 1-4 weeks once all required authorizations are received (subject to facility processing times).

Your case manager will provide weekly updates on the status of the case.

Once records are received, the underwriting team will review them and develop a medical summary and advise of potential underwriting outcomes.

The full file including the cover letter, HIPAA form, application, exam documents (if completed), lab results (if provided), medical records and avocation details will be submitted to the carriers determined to be the best fit related to case design and anticipated underwriting outcomes.

Carriers typically take 5-10 business days to review the file; however, the turn around time is subject to their current processing times.

Once offers are received, you will receive a summary with the tentative offers and the information still needed by the carriers if the offers are subject to additional information.

Thereafter, a formal application needs to be submitted within 30-60 days depending on the carrier to prevent the tentative offer from expiring.

Please note, these are still tentative offers which can change based on a number of factors including but not limited to: carriers' internal checks, doctor visits between the time of the tentative offer and when the application is submitted/underwritten formally, exam/lab results (if not completed at the time of the informal), change in health status, or changes in client responses from the informal application to formal application.

LIFE INSURANCE INFORMAL APPLICATION

TO BE COMPLETED BY AGENT

Client's Name *(First, Middle, Last)*

Details of In Force Coverage Carrier	Replacing YES	 NO	Face Amount	1035/Absolute YES	 NO	Business or Personal	Issue Date
	☐	☐		☐	☐		
	☐	☐		☐	☐		
	☐	☐		☐	☐		

Second Insured *(First, Middle, Last)*

Details of In Force Coverage Carrier	Replacing YES	 NO	Face Amount	1035/Absolute YES	 NO	Business or Personal	Issue Date
	☐	☐		☐	☐		
	☐	☐		☐	☐		
	☐	☐		☐	☐		

PROPOSED COVERAGE

Purpose of Insurance:
_____

Rate Class: _____

Face Amount: _____

Premium Mode:

- ☐ Annual
- ☐ Semi-Annual
- ☐ Quarterly
- ☐ Monthly

Face amount determined by: _____
_____
_____

Term Length if Term Coverage:

- ☐ 10
- ☐ 15
- ☐ 20
- ☐ 25
- ☐ 30

Riders:

- ☐ Return of Premium
- ☐ Waiver of Premium
- ☐ Accidental Death Benefit
- ☐ Child Rider Amount:_____

Permanent:

- ☐ Guaranteed UL
- ☐ Indexed UL
- ☐ Whole Life
- ☐ Survivorship

Riders: _____
_____
_____

Companion app:_____

Guarantee to Age: _____
1035 Exchange Amount: _____
Desired Monthly LTC Benefit: _____

Disability Insurance:

Benefit amount: _____
Benefit period: _____
Elimination period: _____

AGENT INFORMATION

Agent Name	Agent Phone Number
E-mail Address	Date

I understand that errors or omissions on this informal application can impact the formal underwriting assessment. ☐ No ☐ Yes

My Regional Consultant is: _____

My client is planning to have an exam completed for this informal application. No ☐ Yes ☐ - I will order the exam ☐ I would like The Cason Group to order the exam ☐

I have confirmed with my client that he/she will be ready to submit a formal application for the insurance coverage above within 60 days of this submission. No ☐ Yes ☐

I understand that if a formal application is not submitted within 60 days of the informal offers that I may be billed for the records obtained for the informal. No ☐ Yes ☐

I would like The Cason Group's medical consultant to obtain the medical information for the informal application from my client. No ☐ Yes ☐

If yes, please complete the demographic, financial and citizenship/travel information on page 2 AND the ink signed HIPAA form prior to submitting to The Cason Group.

Please note an illustration is required with all informal submissions.

LIFE INSURANCE INFORMAL APPLICATION

FIRST OR SINGLE PROPOSED LIFE INSURED

Name *(First, Middle, Last)*	Date of Birth *(Month/Day/Year)*	Gender	Place of Birth

Address including Zip Code	Phone

Occupation (Please include job duties if applying for disability insurance):

Prior insurance history:	YES	NO	Rating	Company	Reason	Date
Have you ever been declined for insurance?	☐	☐				
Have you ever been offered insurance at other than standard rates, or with benefits restricted?	☐	☐				
Is any other application or informal inquiry pending?	☐	☐				

FINANCIAL INFORMATION

Earned Income: $_____ Unearned Income: $_____ Assets: $_____ Liabilities: $_____

Net Worth: $_____ Date of Last Estate Tax Analysis: _____

Estimated Current Estate Tax Liability: $_____ Estimated Estate Tax Liability at Life Expectancy: $ _____

Have you ever declared bankruptcy? If so, please provide details and dates:_____

CITIZENSHIP/RESIDENCY/TRAVEL

US Citizen:

☐ Yes

☐ No

If no, provide type and expiration date of visa, green card status, and length of time in USA:

_____

Any recent/planned travel outside the US?

☐ No

☐ Yes When (include duration)?_____ Where?_____ Purpose?_____

MEASUREMENTS

Height: _____ feet _____ inches Weight: _____ pounds Any change in weight more than 10lbs in the last 6 months: _____lbs gained _____ lbs lost

Method of weight loss (e.g., diet exercise, medications, unintentional): _____

AGENT INFORMATION

Agent Name

THE CASON GROUP

LIFE INSURANCE INFORMAL APPLICATION

NICOTINE AND ALCOHOL USE

Current Nicotine Use:

- ☐ None
- ☐ Cigarettes - packs per day: _____
- ☐ Cigars - quantity per month: _____
- ☐ Pipe
- ☐ Dip/Chew
- ☐ Nicotine Replacement (e.g. patch or gum)
- ☐ Vape/E-cigarette
- ☐ Other: _____

Alcohol Use:
Number of drinks containing alcohol: _____

Per:
- ☐ Day
- ☐ Week
- ☐ Month
- ☐ Less than Monthly

Previous Tobacco Use *(list each type of tobacco, quantity, and frequency used, and date of last use)*: _____
_____

FAMILY HISTORY (FAMILY HISTORY IS A CONSIDERATION FOR EACH RATE CLASS):

To your knowledge, is there any family history (parent or siblings) of illness due to cardiovascular disease, cerebrovascular disease, diabetes, cancer, or dementia before age 65?

- ☐ Yes
- ☐ No

If yes, please provide full details of the illness including age at onset and age/cause of death if deceased. If the illness is cancer, please include the type of cancer.

- ☐ Father: _____
- ☐ Mother: _____
- ☐ Siblings: _____

AVIATION/AVOCATION

In the past 5 years, have you or do you intend to participate in any of the activities listed?

- ☐ None
- ☐ Piloting an aircraft
- ☐ Mountain climbing
- ☐ Racing
- ☐ Skydiving
- ☐ Scuba diving
- ☐ Other (Please specify): _____

DRIVING/LEGAL HISTORY

Have you had any of the following motor-vehicle-related incidents in the past 10 years?

- ☐ Moving violation
- ☐ Reckless driving
- ☐ DWI or DUI
- ☐ License suspension
- ☐ License revoked

Provide dates, details: _____
Any speeding tickets in the past 3 years?: _____

Have you been convicted of a felony in the last 10 years? If yes, please provide details and dates: _____
_____

BLOOD PRESSURE AND CHOLESTEROL

Latest BP reading: _____/_____ Date: _____ Latest total cholesterol: _____ mg Date: _____

Latest total cholesterol/HDL ratio: _____

Have you ever taken or are you currently taking any medication for blood pressure?

- ☐ No
- ☐ Yes, name of medication: _____

Have you ever taken or are you currently taking any medication to lower cholesterol?

- ☐ No
- ☐ Yes, name of medication: _____

* Personal health information protected by HIPAA regulations *

MEDICAL HISTORY

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply:

- ☐ Alcohol use disorder/ at risk drinking
- ☐ Alzheimer's/dementia/cognitive impairment
- ☐ Asthma/COPD/other lung condition
- ☐ Barrett's esophagus/GERD
- ☐ Blood disorder
- ☐ Bone/joint/muscle/skin disorder
- ☐ Cancer (or precancerous conditions: type: _____)
- ☐ Cirrhosis/fatty liver disease
- ☐ Coronary artery or other heart disease
- ☐ Depression/anxiety/other psychiatric illness (Please specify:_____)
- ☐ Glucose intolerance/diabetes (Type: ☐1 ☐2; Hgb A1c_____)
- ☐ Heart murmur/valve disease
- ☐ Hepatitis (type: _____)
- ☐ Illicit substance use
- ☐ Inflammatory bowel disease (e.g. Crohn's disease or ulcerative colitis)/other GI condition
- ☐ Irregular heartbeat/palpitations
- ☐ Kidney disease
- ☐ Lupus
- ☐ Marijuana/CBD use (☐ recreational ☐ prescribed) Amount/frequency of use:_____
- ☐ Multiple sclerosis/seizures/other neurological disorder
- ☐ Peripheral vascular disease
- ☐ Reproductive or genitourinary system disorders
- ☐ Rheumatoid arthritis or other rheumatic/ autoimmune disorders
- ☐ Sleep apnea or other sleep disorder (☐ prior sleep study ☐ uses CPAP)
- ☐ Stroke or other cerebrovascular disease

Additional details or conditions not specified above: _____

_____

Any past surgeries or procedures:_____

_____

Please provide the name and contact information for your primary medical providers:

_____

_____

List dates, diagnosis, details, treatments (including past surgeries/operations), plus names, addresses, and phone numbers of any other physicians consulted in the last 5 years:

_____

_____

_____

_____

_____

_____

_____

_____

List current/recent medications. Please include reason for medication if not specified above:

_____

_____

_____

_____

_____

_____

SIGNATURES

The Proposed Life Insured (or Parent or Guardian) has read the statements and answers herein and they are complete and true to the best of his / her knowledge and belief. The Proposed Life Insured (or Parent or Guardian) acknowledges receipt of the Notice of Disclosure of Information.

Signed at _____ City _____ State _____ This _____ Day of _____ Year _____

Signature of Agent / Registered Representative (as Witness) _____

Signature of Proposed Life Insured (Parent or Guardian, if under age 10) _____

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT ("HIPAA")
AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Name of Patient / Proposed Insured (Please Print)_____

Date of Birth _____

I, hereby, authorize all of the people and organizations listed below to give The Cason Group, Inc., and their authorized representatives, including agents and insurance support organizations, including but not limited to RSA Medical, the following information:

Any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments or surgeries, hospital confinements for physical and mental conditions, use of drugs or alcohol, prescription records and history of medications prescribed and communicable diseases including HIV or AIDS

I, hereby, authorize each of the following entities to provide the information listed above:

- Any physician or medical practitioner
- Any hospital, clinic or other health care facility
- Any insurance or reinsurance company (including the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage)
- Any consumer reporting agency or insurance support organization
- My employer, group policy holder or benefit plan administrator
- The Medical Information Bureau (MIB)
- Any prescription and/or medical claims database sources

I understand that the information obtained will be used by the recipient to:

- Determine my eligibility for insurance
- Underwrite my application for insurance
- Determine my eligibility for benefits under any temporary insurance
- If a policy is issued, determine my eligibility for benefits and contestability of the policy

I, hereby, acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the recipient will be used and disclosed as described in the General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: The Cason Group, Inc. 1612 Marion St. Columbia, SC 29201. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary. However, if I do not sign the authorization, the Companies many not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Proposed Insured or
Proposed Insured's Personal Representative Date

Description of Authority of Personal Representative
(If Applicable)

NOTICE OF EXCHANGE OF INFORMATION & FAIR CREDIT REPORTING ACT NOTICE

The information regarding your insurability will be treated as confidential. However, the life insurance companies listed on this form, or its reinsurers, at the time of your signature, may make a brief report to the Medical Information Board, a nonprofit membership organization of life insurance companies, which operates an information exchange for its members. If you apply for life or health insurance to another company, which is also a member of the Bureau, or, if a claim for benefits is submitted to such a company, the Bureau, will, upon request, supply the information on this file to that company. The life insurance companies listed on this form or its reinsurers, at the time of your signature, may also release information in its file including information given in your application to other insurance companies to which you apply for life or health insurance or to which a claim is submitted. Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician). If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is PO Box 105, Essex Station, Boston, MA 02112, Telephone: 617-426-3660.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

I, hereby, authorize any licensed physician, medical practitioner, psychotherapist, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has any records or knowledge of me or my health or treatment, to give The Cason Group, Inc. any such information. The information, which may be disclosed includes records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, prescription records and history of medications, medical claims/billing data, character habits, avocations, finances, general reputation, credit or other personal traits.

To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency or investigative company employed by The Cason Group, Inc., including but not limited to RSA Medical, to collect and transmit such information. I further authorize The Cason Group, Inc. to prepare or obtain an investigative consumer report in connection with this application.

The life insurance companies listed on this form or its reinsurers, at the time of your signature may secure personal interviews with third parties such as family members, business associates, financial sources, friends or others with whom you are acquainted concerning your character, general reputation, person characteristics and mode of living. Upon written request, additional information will be provided as to the nature and scope of the report, if one is made.

AIG/American General
ALLIANZ Life
Americom
Americo
American National
Amerus
Assurity Life
Banner Life/LGA
Bankers Life of NY
Brighthouse
Chase
Chesapeake Life
Cincinnati Life
Corebridge
Coventry First
Empire General
Fidelity & Guaranty
First Penn Pacific
General American
Genworth
Guaranteed Trust Life
Illinois Mutual
Indianapolis Life
ING Reliastar
Jefferson National
Jefferson Pilot
John Hancock
Life Settlement Alliance
Lincoln Benefit
Lincoln Financial Group
Manulife
Mass Mutual
MET Life Investors
Mutual of Omaha
Nationwide
North American Co for L&H
OneAmerica
Petersen International
Presidential Life
Principal National Life Ins. Co
Principal Life Ins. Co
Protective Life
Prudential Life
Reliastar Life of NY
RGA
Secured Financial Group
Securian
Security Mutual Life
Sun Life Financial
The Standard
Transamerica Ins. & Invest.
Transamerica of NY
Transamerica Travelers U.S.
Financial Voya
West Coast Life
William Penn

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

DOB

SSN