19000 MacArthur Blvd, Suite 450
Irvine, CA 92612
P: 714-820-4489 • F: 714-627-4646
www.AdvisorHQ.com

Private-Informal Life Insurance Application

Agent Information

Name:	**Company:**
Phone:	**E-mail:**

Client Information

Name:	**DOB:**	
Gender:	**Social Security #:**	
Occupation:	**Marital Status:**	
Phone:	**E-mail:**	
Street Address:		
City:	**State:**	**Zip:**

Client Advisors

Relationship	Name	Phone	E-mail
Attorney			
CPA			

Existing Insurance Coverage

Policy Number	Company	Amount	Type	Issue Date

Desired Insurance

Life Insurance

Amount(s):	**Riders:**	**Accidental**	**Chronic**	**LTC**	**ROP**
Term Length:	**10 Yr**	**15 Yr**	**20 Yr**	**25 Yr**	**30 Yr**
UL to Age:	**85**	**90**	**95**	**100**	**120**

Comments / Notes:

Client Insurance Profile

Approximate Height:	Approximate Weight:

Tobacco or Marijuana Use in the past 5 year? (If none leave blank)

Product	Date Last Used	Amount / Frequency
Cigarettes		
Cigars		
Other (Marijuana, Pipe, Dip)		

Currently taking any medications? (If Yes list details below)

Medication Name	Reason Taking	Length / Frequency / Dosage

Have you ever been treated for or diagnosed with any of the following?

Alcohol/Drug Abuse:	Alzheimer's:	Arthritis:
Anemia/Blood Disorder:	Asthma/COPD:	Brain Disorder:
Cancer:	Dementia:	Depression:
Diabetes:	Heart Attack:	Heart Disease:
Joints/Bones:	Kidney Issues:	Liver Issues:
Neurological Issues:	Pancreas Issues:	Sleep Apnea:
Stroke/TIA:	Tumors/Cysts:	Other:

Family History (please list any history of Heart Disease or Cancer)

Relationship	Age if Living	Age at Death	Present Health or Cause of Death
Father			
Mother			
Brother(s)			
Sister(s)			

Have you had any major surgeries or illnesses in the past 10 years?

If yes, list dates, surgery type, condition, and current status of condition:

Driving & Criminal History:	
Driving Violation (Past 5 Years Tickets):	
DUI/DWI (Past 10 Years):	Felony (Ever):

Non-US Citizens	
Place of Birth:	Country of Citizenship:
Do you have a Green Card?	Own Property or a Business in the US?
Provide Visa Type, Number, & Expiration Date:	

Foreign Travel (outside of US or Canada)

	Past 3 Years	Current 12 Months	Next 12 Months
Destination(s)			
Dates			
Duration of Stay			
How Often			
Purpose of Trip			

Additional Comments Notes:

List of Doctors (Seen in past 5 years)

Doctor One (Primary)	
Name:	Specialty:
Date Last Seen:	Reason:
Phone:	City / State:

Doctor Two	
Name:	Specialty:
Date Last Seen:	Reason:
Phone:	City / State:

Doctor Three	
Name:	Specialty:
Date Last Seen:	Reason:
Phone:	City / State:

Doctor Four	
Name:	Specialty:
Date Last Seen:	Reason:
Phone:	City / State:

Financial Supplement

Income Details

Annual Earned Income	
Salary or Draw	
Bonus/Commissions	
Other Earnings	
Total Earned Income	
Spouse's Income	

Annual Unearned Income	
Dividends/Interest	
Net Rentals	
Other Unearned	
Total Unearned	

Assets & Liabilities

Assets		Liabilities	
Cash		Primary Mortgage	
Primary Residence		Other Mortgages	
Other Real Estate		Personal Loans	
Business Equity		Credit Cards	
Stock/Bonds		Other	
Other Assets			
Total Assets		Total Liabilities	

Total Net Worth	

Bankruptcy History

Have you ever filed for bankruptcy?	
Type (if Yes):	Date:

Comments / Notes:

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AUTHORIZATION FOR RELEASE OF INFORMATION OF INSURED

By executing this Authorization for Release of Information of Insured (this "Authorization Form"), the undersigned authorizing person, who is and/or seeks to be insured (the "Insured") under one or more life insurance policies, or who is duly authorized to act on behalf of the Insured if not the Insured, acknowledges the necessity for personal and protected health, medical, and other information, documentation, and records regarding the Insured to be released to Insurance Marketing Services, Inc., d/b/a Advisor HQ and d/b/a Advisor HQ; Bodymatter, Inc.; LifeRoc Capital, LLC; and their respective affiliates, assigns, and designees (collectively, the "Recipients"; each, a "Recipient"), to facilitate review and/or underwriting by the Recipients of one or more proposed life insurance-related or other transactions with one or more Recipients, which relate to and/or involve the Insured, as well as for all other legal purposes, without limitation.

The undersigned hereby authorizes and instructs [A] any health care provider, not limited to any type or source; [B] each insurer identified in the "Insurer List" below in this Authorization Form (each, an "Insurer"), any affiliate of any Insurer, any reinsurer of any Insurer, and any successor-in-interest of any Insurer and/or of its respective affiliates and reinsurers; [C] any insurance support organization; [D] any consumer, credit, and/or public record reporting agency or entity, including but not limited to LexisNexis, Westlaw, TransUnion, Experian, Equifax, and their respective affiliates; [E] any person authorized to represent any person or entity described by any or all of Items [A] through [D] immediately above, inclusive, for any purpose described in this Authorization Form; and [F] all other persons and entities having knowledge or records of the Insured and/or the diagnosis, treatment, and prognosis with respect to any physical and/or mental condition of the Insured (collectively, the "Authorized Parties"), to release, disclose, and provide to each Recipient, without delay or restriction: [1] any and all individually identifiable health information regarding and/or relating to the Insured, including but not limited to medical records, reports, pharmaceutical and prescription drug records, diagnostic testing, and lab results, including but not limited to such relating to diagnosis or treatment of Human Immunodeficiency Virus, sexually transmitted diseases, and suicidal or mental disorders; [2] all other information concerning the health of the Insured, without limitation; and [3] all other information regarding the Insured as allowed and/or required by applicable law, including but not limited to credit, employment, and consumer background information (items [1], [2], and [3], together, "Insured Information").

For purposes of this Authorization Form, the Insurer List (the "Insurer List") consists of the following insurers:

- **Accordia Life**
- **American General**
- **Ameritas Life**
- **Allianz**
- **American National**
- **Assurity**
- **AXA Equitable**
- **Foresters**
- **Genworth Financial**
- **John Hancock**
- **Lafayette Life**
- **Legal & General**
- **Lincoln National**
- **LSW**
- **MetLife Investors**
- **Minnesota Life**
- **Mutual of Omaha**
- **NACOLAH**
- **Nationwide**
- **New York Life**
- **Penn Mutual**
- **Principal Life Insurance Company**
- **Principal National Life Insurance Company**
- **Protective Life**
- **Prudential Life Insurance Co. of America**
- **Pruco Life Insurance Company**
- **Sagicor Life**
- **SBLI**
- **Symetra Life**
- **Transamerica**
- **VOYA Life**
- **Zurich American Life**
- **VOYA Life**
- **Zurich American Life**

The undersigned acknowledges and agrees that this Authorization Form permits, but does not require, Recipients to seek and obtain Insured Information from any of the Authorized Parties, and that the Recipients shall not be liable for any consequences which follow from any Recipient seeking or not seeking Insured Information, in whole, in part, or otherwise, from any of the Authorized Parties.

This Authorization Form is valid for a period of twenty-four (24) months following the latest date set forth below unless this Authorization Form is validly rescinded by the undersigned prior to the expiration of that time period, provided, however, any otherwise-valid revocation of this Authorization Form is not effective to the extent any person or entity acts in good faith reliance on this Authorization Form. If for any reason the undersigned desires to rescind this Authorization Form, the undersigned may do so in a signed writing clearly indicating that intent, delivered to:

Insurance Marketing Services, Inc.
d/b/a Advisor HQ
19000 MacArthur Boulevard, Suite 450
Irvine, CA 92612

The undersigned further understands that disclosures made pursuant to this Authorization Form may be further disclosed by Recipients to third parties and no longer subject to protection by state, federal, and/or municipal laws, regulations, and rules governing privacy and confidentiality.

The undersigned shall hold Recipients harmless in the event of unauthorized access to or use of any Insured Information obtained by any Recipient.

The undersigned acknowledges that authorizing disclosure of Insured Information through this Authorization Form is voluntary, that the undersigned can refuse to sign this Authorization Form, and that the undersigned need not sign this Authorization Form in order to assure treatment, payment, enrollment or eligibility for insurance benefits by the Recipients.

By signing this Authorization Form, the undersigned acknowledges and agrees that this Authorization Form is written in plain English, that the undersigned has read and fully understands this Authorization Form in its entirety, that the undersigned has received a copy of this Authorization Form to keep, and that a photocopy or facsimile of this Authorization Form, once completed, signed by the undersigned, and witnessed, is as valid as, and shall be treated as, an original of such signed Authorization Form.

Insured Information	
Print Insured Name:	
Date of Birth:	**Gender:**
Authorizing Person Information (signing solely in that capacity)	
Print Name:	
Print Title (if applicable):	
Relation to Insured:	
Signature:	**Date:**

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AUTHORIZATION FOR RELEASE OF POLICY INFORMATION

By executing this Authorization for Release of Policy Information (this "Authorization"), the undersigned person ("Signatory"), owner of one or more life insurance policies or duly acting on behalf of such owner ("Policyowner", who may or may not also be Signatory), hereby authorizes the insurance carrier identified below, and its respective affiliates, assigns, and designees (collectively, "Insurer"), to release to Insurance Marketing Services, Inc., d/b/a Advisor HQ, and its respective officers, directors, employees, agents, representatives, affiliates, assigns, and designees (collectively, "AHQ"), by voice, phone, facsimile, e-mail, mail, and/or other commercially-reasonable means of transmission (as the context reasonably supports), any and all information and/or documentation which AHQ requests in connection with the Policyowner and/or life insurance coverage on the life of the Insured (as identified below in this Authorization), without limitation, including but not limited to financial and credit-related information of Policyowner, a true, correct & complete copy of the life insurance policy described below (the "Policy"), certificates evidencing the issuance and in-force status of the Policy, annual statements, in-force Illustrations, verifications of coverage, account values, Policy information, Insurer forms, rider or amendment details, and other Policy-specific or related information, to enable AHQ to evaluate current and future life insurance and other financial planning needs of the Policyowner. Signatory may revoke this Authorization in writing if such revocation is delivered to AHQ via first-class certified postage-prepaid mail, return receipt requested. Any otherwise-valid revocation of this Authorization by Signatory is not effective to the extent AHQ and/or Insurer acts in good faith reliance on this Authorization.

Policy Information	**Insured Information**
Carrier Name:	**Insured Name:**
Policy Number:	**Insured SSN:**
Owner Information	
Owner Name:	
Owner TIN or SSN:	**DOB (if applicable):**
Information About Authorized Recipients	
Authorized Recipient Entity Name Insurance Marketing Services, Inc. d/b/a Advisor HQ	**Authorized Employees of Authorized Recipient** Aaron Giroux, Sean Giroux (Vice Presidents); Norman Giroux (Director of Marketing); Brandon Marz (Brokerage Director); Eva Rodriguez (Case Managers); Kim Brassell (New Business Supervisor) Tooba Syed (New Business Assistant)

Signature & Authorization

This Authorization may be signed in any number of counterparts, which together shall constitute one and the same Authorization, and a photocopy or facsimile of this signed Authorization shall be treated, and may be relied upon, as an original. **By signing this Authorization below where indicated, Signatory acknowledges and agrees that this Authorization is written in plain English, that Signatory has read and fully understands this Authorization, and that Signatory will retain a copy of this Authorization, once duly completed and signed by Signatory, for his, her, or its records, respectively.**

Owner Name:	**Relation to Insured:**
Owner Signature:	**Date:**