Preliminary Application

Individual Insurance

Toll-Free: 800-325-8907 Fax: 954-926-8468
www.seemanholtz.com

Personal History

Name _____ ☐ Male ☐ Female SS# _____

Address _____ City _____ State _____ Zip _____

E-Mail _____ DOB _____ Age _____ Height _____ Weight _____

Occupation _____ Phone Number _____

Drivers License Number _____

Insurance Desired

☐ Universal Life

☐ Term, Level

☐ Survivorship*

☐ Variable

Smoker: ☐ Yes ☐ No If yes, todays date: _____ Date of Last Nicotine: Use _____

Specify Tobacco Type: _____ Face Amount Desired: _____

Premium Amount Desired: _____ ☐ Annual ☐ Monthly

Purpose of Insurance: _____

*If both have insurability questions, please complete this form for each applicant.

Other Insurance In Force

Total Amount in Force _____ Date of Last Application _____ Is This to Replace Insurance? ☐ Yes ☐ No

Name of Company _____ If so, Premium Being Replaced _____

Writing Agent Information

Name _____ Phone _____ Fax _____

Address _____ City _____ State _____ Zip _____

Name of Broker Dealer (if applicable) _____ Reference Number _____

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Client Name _____

E-Mail _____

Medical History - Attending Physician Statement References

Personal Physician/ Internist:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Dermatologist:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Cardiologist:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

OB / GYN:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Urologist:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Miscellaneous:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Oncologist:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Psychiatrist

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Neurologist / Neurosurgeon:

Name: _____
Phone: _____
Fax: _____
Condition: _____
Address, City, State: _____

Medications and Doses:

_____
_____
_____
_____
_____

Family Health History

Additional Disclosure Space Included on Following Page

	Age (If Deceased)	Age (If Living)	History of Heart Disease or Circulatory Disorder	History of Cancer, all types
Mother				
Father				
Sister(s)				
Brother(s)				

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Client Name _____

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Medical History

Use this space to disclose additional medical history from page two

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Carriers

AIG
ACACIA
ADVANCED SETTLEMENT
AETNA
AFLAC
ALLAMERICAN LIFE
AMERICAN GENERAL
AMERICAN NATIONAL
AMERICAN SCANDIA
AMERITAS
AMERUS
ATHENA
ATLAS
AVS
AXA
BANNER LIFE
BC/BS HEALTH OPTIONS
BEDROCK
BELMAN KLEIN
BERKSHIRE LIFE
CAMBRIDGE, LLC
CANADA LIFE
CASE PROFESSIONAL RESOURCES
CIGNA
COLUMBUS
COLOMBIAN MUTUAL
CONNECTICUT MUTUAL
CONNECTICUT
DIMENSION
EMPIRE GENERAL LIFE
EQUITABLE
FASANO
FEDERAL HOME LIFE
F&G LIFE
FIDELITY SECURITY
FIRST COLONY
FIRST PENN-PACIFIC
GE LIFE & ANNUITY
GENERALAMERICAN
GECA
GOLDEN RULE
GUARANTEE
GUARDIAN
HARTFORD
IBU, INC
ILLINOIS MUTUAL
INDIANAPOLIS LIFE
ING
JACKSON NATIONAL
JEFFERSON PILOT LIFE
JOHN HANCOCK
LIFE BROKERAGE PARTNERS
LIFE OF SOUTHWEST
LINCOLN BENEFIT
LINCOLN LIFE
LINCOLN NATIONAL
MASS MUTUAL
METROPOLITAN
MIDLAND
MUTUAL OF OMAHA
NATIONAL LIFE OF VERMONT
NATIONAL INSURANCE BROKERAGE (NIB)
NATIONWIDE INSURANCE
NEW ENGLAND
NFP
NORTH AMERICAN
NORTHBRIDGE INSURANCE
PACIFIC LIFE
PAN AMERICAN
PENN MUTUAL
PHOENIX LIFE
PRESIDENTIAL
PRINCIPAL FINANCIAL
PROTECTIVE LIFE
PROVIDENT MUTUAL
PRUDENTIAL
PVA
RELIASTAR LIFE
SECURITY MUTUAL
SECURITY-CONN
SECURITY LIFE OF DENVER
SIERRA LIFE
STANDARD
STATE LIFE INSURANCE CO.
SUN LIFE
SWISS RE
TRANSAMERICA
TWENTY FIRST
UNION CENTRAL
UNITED AMERICAN
UNITED HEALTH CARE
UNITED OF OMAHA
UNITED STATES LIFE
UNUM
US FINANCIAL
WARD BELL
WEST COAST LIFE
WESTERN RESERVE LIFE
WILLIAM PENN
XL LIFE INSURANCE & ANNUITY
ZURICH KEMPER

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Client Name _____

E-Mail _____

Authorization

I authorize Seeman Holtz, its affiliates, its reinsurers, insurance support organizations, and their representatives to obtain medical and other information in order to evaluate this application for insurance. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc, employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other insurance coverage, or has or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to Seeman Holtz and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. Per HIPAA regulations, the purpose of this authorization is to determine my eligibility for and apply for insurance products and services. I understand that I may refuse to sign this authorization but that if I do refuse to sign, Seeman Holtz may not be able to fulfill the purpose of this authorization. This authorization shall be valid for thirty (30) months from the date signed below, unless I revoke it, in writing. I understand that I may revoke this authorization at any time by writing to 300 Yamato Rd, Ste. 2222, Boca Raton, FL 33431; however any action taken in reliance on this authorization prior to the notice of revocation shall be valid. I acknowledge that the information to be disclosed may be protected under state and federal privacy laws and regulations. Once this information is disclosed, it ma be subject to redisclosure and no longer be covered by those laws and regulations. A photocopy of this authorization shall be as valid as the original, and I understand that I will be given a copy of this authorization. I understand that settlement providers, their medical underwriters, contingency reinsurers and any other entity which requires or is compelled by law to receive such health information to complete a life settlement transaction or in order to sell a life settlement contract (each an "Authorized Recipient") will use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of life insurance policy (ies) of which I am the owner or which I am the insured, and I hereby expressly authorize such use and disclosure of my health information made under this authorization. By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional , hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction. This protected health information is to be disclosed under this Authorization so that Seeman Holtz may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Seeman Holtz. This authorization shall remain in force for thirty (30) months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request. Such request for revocation is not effective to the extent that any of My Providers have relied on this Authorization to provide information or to the extent that Seeman Holtz has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Seeman Holtz may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Print Name of Proposed Insured / Patient: _____ DOB: _____

Print Name of Additional Proposed Insured / Patient: _____ DOB: _____

Signature of Proposed Insured / Patient or Personal Representative: _____ DATE: _____

Signature of Additional Proposed Insured / Patient or Personal Representative: _____ DATE: _____

I have read this authorization and understand that I have a right to receive a copy. I acknowledge that I have been informed of my right to receive the following notices: Privacy and the Fair Credit Reporting Act, Medical Information Bureau Disclosure Notice, and Description of Information Practices.

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient: