

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 lifenebusiness@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.

TO BE COMPLETED BY AGENT

Client's Name (First, Middle, Last)

Details of In Force Coverage Carrier	Replacing		Face Amount	1035/Absolute		Business or Personal	Issue Date
	YES	NO		YES	NO		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		

Second Insured (First, Middle, Last)

Details of In Force Coverage Carrier	Replacing		Face Amount	1035/Absolute		Business or Personal	Issue Date
	YES	NO		YES	NO		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>		

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
 Companion app: _____

Riders: _____

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.



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?	<input type="checkbox"/>	<input type="checkbox"/>				
Have you ever been offered insurance at other than standard rates, or with benefits restricted?	<input type="checkbox"/>	<input type="checkbox"/>				
Is any other application or informal inquiry pending?	<input type="checkbox"/>	<input type="checkbox"/>				

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

NICOTINE AND ALCOHOL USE

Current Nicotine Use:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Dip/Chew |
| <input type="checkbox"/> Cigarettes - packs per day: _____ | <input type="checkbox"/> Nicotine Replacement (e.g. patch or gum) |
| <input type="checkbox"/> Cigars - quantity per month: _____ | <input type="checkbox"/> Vape/E-cigarette |
| <input type="checkbox"/> Pipe | <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Skydiving |
| <input type="checkbox"/> Piloting an aircraft | <input type="checkbox"/> Scuba diving |
| <input type="checkbox"/> Mountain climbing | <input type="checkbox"/> Other (Please specify): _____ |
| <input type="checkbox"/> Racing | |

DRIVING/LEGAL HISTORY

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

- | | |
|---|--|
| <input type="checkbox"/> Moving violation | Provide dates, details: _____ |
| <input type="checkbox"/> Reckless driving | |
| <input type="checkbox"/> DWI or DUI | Any speeding tickets in the past 3 years?: _____ |
| <input type="checkbox"/> License suspension | |
| <input type="checkbox"/> License revoked | |

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: _____

LIFE INSURANCE INFORMAL APPLICATION

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol use disorder/ at risk drinking | <input type="checkbox"/> Glucose intolerance/diabetes
(Type: <input type="checkbox"/> 1 <input type="checkbox"/> 2; Hgb A1c _____) | <input type="checkbox"/> Multiple sclerosis/seizures/other neurological disorder |
| <input type="checkbox"/> Alzheimer's/dementia/cognitive impairment | <input type="checkbox"/> Heart murmur/valve disease | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Asthma/COPD/other lung condition | <input type="checkbox"/> Hepatitis (type: _____) | <input type="checkbox"/> Reproductive or genitourinary system disorders |
| <input type="checkbox"/> Barrett's esophagus/GERD | <input type="checkbox"/> Illicit substance use | <input type="checkbox"/> Rheumatoid arthritis or other rheumatic/autoimmune disorders |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Inflammatory bowel disease (e.g. Crohn's disease or ulcerative colitis)/other GI condition | <input type="checkbox"/> Sleep apnea or other sleep disorder
(<input type="checkbox"/> prior sleep study <input type="checkbox"/> uses CPAP) |
| <input type="checkbox"/> Bone/joint/muscle/skin disorder | <input type="checkbox"/> Irregular heartbeat/palpitations | <input type="checkbox"/> Stroke or other cerebrovascular disease |
| <input type="checkbox"/> Cancer (or precancerous conditions: type: _____) | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Cirrhosis/fatty liver disease | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Coronary artery or other heart disease | <input type="checkbox"/> Marijuana/CBD use (<input type="checkbox"/> recreational <input type="checkbox"/> prescribed)
Amount/frequency of use: _____ | |
| <input type="checkbox"/> Depression/anxiety/other psychiatric illness
(Please specify: _____) | | |

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

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

DOB

SSN