TexIns Solutions, Ltd.
7435 Hollister Road, Houston Texas 77040
Preliminary Inquiry & Authorization
NOT AN APPLICATION FOR LIFE INSURANCE
(Use Reverse Side If Additional Space Is Needed)

Personal History (Please Use A Separate Form For Each Person)

Name_____Male_____ Female_____

Address_____ City_____ State_____ Zip_____

DOB ___/____/____ Age _____ Occupation _____ Duties_____

SS#_____ Driver's License State and #_____

Contact Phone #_____

1. Have you ever smoked cigarettes? Yes____ No ____ If yes, how many daily? _____
   If habit has been discontinued, when? _____
2. Do you use tobacco in any other form? Yes ___ No ___ If, yes, type and frequency_____
3. Have you ever been rated or declined for Life Insurance Coverage? Yes____ No ____
   If yes, give reason and table rating _____
4. Have you ever:
   a. had any surgery or been advised to have surgery and not done so? Yes ____No____
   b. been in a hospital, sanitarium or other institution for observation, rest, diagnosis or treatment? Yes____ No ____
   c. used or are you now using, cocaine, amphetamines, marijuana, heroin, or other drugs except as legally prescribed by a doctor? Yes ____ No ____
   d. been treated or counseled for alcohol or drug use? Yes ____ No _____

5. Height _____ Weight _____ Weight Change in last year _____

6. Have you ever been treated or are currently being treated for :

___ High Blood Pressure
___ Cancer
___ Digestive Disorders
___ Epilepsy/ Nervous Disorders
___ Kidney Disease
___ Rhuematoid Arthritis
___ Lupus
___ Alzheimer's/ Dementia
___ COPD
___ Depression/ Anxiety Disorder
___ Heart Murmur / Valve Disease
___ Liver Disease
___ Sleep Apnea
___ Asthma
___ Coronary Artery Disease
___ Diabetes
___ Hepatitis
___ Multiple Sclerosis
___ Stroke

Details to "Yes" answers for questions 4a, b, c, d, e & 6.

Diagnosis	Date of Onset	Treatment, Meds., & Details	Name & Address of Physician/Date Last Seen

Personal Physician (name, address & phone #)_____

_____

Date/Reason Last Seen_____

Family Record

	Current Age or Age at Death	Year and Cause of Death
Father	_____	_____
Mother	_____	_____
Brother	_____	_____
Brother	_____	_____
Sister	_____	_____
Sister	_____	_____

Aviation/Avocation/Travel

Have you flown within the last 5 yrs. as a pilot, student pilot or crew member of any aircraft or as a passenger on other than a scheduled airline, or expect to make such a flight?_____(if yes aviation questionnaire needed).

Do you engage in automobile or motorcycle racing, parachuting, skydiving/B.A.S.E. jumping, hang gliding, Scuba diving or other hazardous sport?_____(if yes avocation supplement needed).

Do you intend to reside or travel out of the United States or Canada?_____ If so, where, purpose and for how long ?

Have you had any moving violations or DUI's in the last 5 years?_____

Death Benefit

Plan of Insurance: Universal Life ____Whole Life____Term ____#Years ____Joint & Survivorship____

Term Face amount $_____ Permanent Face Amount $_____

Specify carriers that you would like to us to submit this trial application _____

_____

Is this case currently being considered by another impaired risk agency? Yes ____ No ____

In-force Insurance

Company	Amount	Type (Individual or Group)	To be replaced
	$		
	$		
	$		
	$		

OTHER INFORMATION

In some cases, an insurer evaluating this request may ask a consumer reporting agency to complete an investigative consumer report about you. You have the right to request to be in interviewed in connection with the preparation of that report. In such a case, do you wish to be interviewed? Yes____ No ____

Additional Remarks

Agent Information

Name _____

Email Address _____

Phone _____Fax _____

HIPPA Authorization to Obtain and Disclose Information

I understand that the life insurance companies named below, their Reinsurers, any insurance support organizations (e.g., MIB, Inc.) and the authorized representatives of those companies may need to collect information about me in regard to proposed life insurance coverage. I understand that if I do not sign this authorization, these companies may not be able to evaluate my eligibility for insurance. I also understand that no health care provider or health care plan may condition treatment or eligibility for benefits on my signing this authorization.

I authorize any licensed physician, medical practitioner, hospital, clinic, other health care provider, health plan, insurance company, MIB, Inc., or other organization or person to give information, records and data about me or my mental or physical health to any of the companies below and/or their authorized agents to determine my eligibility for life insurance coverage. This information may include all such information for the prior ten (10) year period including information regarding communicable or venereal diseases and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). It may also include information about any history of alcohol or drug treatment, including information subject to the protections of 42 CFR Part 2. To facilitate rapid submission of such information to the companies below, **I further authorize** these sources to give such information to TexIns Solutions, Ltd.

I understand that once released, the information may no longer be protected by federal laws and regulations and that the companies may disclose information received to their re-insurers, affiliates, MIB, Inc., other persons who perform business, professional, or insurance tasks for them or as otherwise permitted by law.

This authorization is valid for 2 years after the date shown below, unless revoked prior to that date. I may revoke this authorization by notifying TexIns Solutions, Ltd. in writing at 7435 Hollister Rd., Houston, Texas 77040. However, any action taken by TexIns Solutions, Ltd. or the companies below prior to being notified of revocation will be valid. A photo of this form is as valid as the original. I may have a copy of this form upon request.

I represent that the statements and answers are true, complete and correctly recorded. I represent this to the best of my knowledge.

Signed at_____ **This**_____ **Day of**_____ **20**_____

Name and Date of Birth of Proposed Insured:

DOB

Please print:_____ **(/ /);**

Signature of Proposed Insured or Legal Representative of Proposed Insured X:

_____

If Legal Representative, describe authority:_____

Agent Name_____ **Agent Signature**_____

Insurance Companies:

AIG Life Insurance Co., Allianz Life, American General, American National, American Heritage, Aviva, AXA, Banner Life, Cambridge Financing Company, Columbus Life, Coventry Capital I, LLC, Credit Suisse (CSFB),First Choice Network, LLC, First Colony Life, First Penn Pacific, GE Capital Assurance, General American Life, Hartford Life, Indianapolis Life, ING-Reliastar Life, ING-Security Life of Denver, ING USA Annuity & Life, Isthmus Capital, LLC; Jackson National, Jefferson Pilot Financial Insurance. Co, Jefferson Pilot Life Insurance Co., Jet Stream Copy, John Hancock, Life Settlement Providers, LLC, Lincoln Benefit, Lincoln National, Mass Mutual, Minnesota Life Insurance Co., Met Life Investors, MONY, Nationwide Life, North American Co Life Insurance, New York Life, Polaris Capital, PVA Pacific Life, Park Venture Advisors, LLC, Penn Mutual, Phoenix Life, Principal National Life Insurance Company, Principal Life Insurance Company, Protective Life, Prudential Life Ins, ShareFile, Strategic Medical Consulting, Inc., Summit Alliance, Sun Life of Canada, TexIns Solutions, Ltd., Transamerica, UNUM, Union Central, United of Omaha Life, West Coast Life, Welcome Funds Inc.; Western Reserve, Zurich Life.

TexIns Solutions, Ltd.

NOTICE TO PROPOSED INSURED(S)

THIS IS A VERY GENERAL DESCRIPTION OF INSURANCE INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION, ASK YOUR AGENT. IF YOU ARE INTERESTED IN THE PRACTICES OF A SPECIFIC INSURANCE COMPANY, YOU SHOULD CONTACT THE COMPANY DIRECTLY.

INSTRUCTIONS TO THE AGENT: THIS FORM MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

Information regarding your insurability will be treated as confidential.

In the course of reviewing your request for insurance, insurance companies rely primarily on information provided by you. They may also seek information from others, such as medical professionals, who have treated you pursuant to any authorization you signed.

In some situations, and in compliance with applicable law, they may disclose necessary items of information to third parties, including re-insurers and to law enforcement and regulatory agencies to prevent insurance fraud, without your specific authorization. In other cases, information may be released to other life insurance companies to whom you may apply, or to whom a claim for benefits may be submitted, pursuant to your signed authorization.

MIB, INC.

Companies that are members of MIB, Inc. (a non-profit membership organization of life insurance companies, which operates an information exchange bureau on behalf of its members) may make brief reports to MIB, Inc.. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in its file, you may contact MIB, Inc. and seek a correction. The address is: P.O. Box 105, Essex Station, Boston, MA. 02112; Phone (617) 426-3660.