7230 Lee DeForest Drive, Suite 105
Columbia, Maryland 21046
Phone: (410) 312-0003
Email: capmet@capitolmetro.com
www.capitolmetro.com

PRELIMINARY APPLICATION

Name:		DOB:	Social Security Number:
Gender:	Height:	Weight:	Chest Exceed Waist: ☐ Yes ☐ No
Face Amount:	Product Type:		In force Insurance Amount:

Ever used Tobacco Products? ☐ Yes ☐ No If yes, type of tobacco use, frequency & amount: _____

Currently use Tobacco? ☐ Yes ☐ No If no, Date of Last Use: _____

Current Blood Pressure Reading: _____ Total Cholesterol Reading: _____ HDL Reading: _____

Any planned foreign travel? ☐ Yes ☐ No Purpose of Trip ☐ Business ☐ Personal
If yes, provide location (city/country), frequency, and duration for each trip.

Do you have any moving violations in the last 5 years? If yes, provide dates and details. ☐ Yes ☐ No

Family History: Does either parent have a history of diabetes, cancer, stroke or heart disease? ☐ Yes ☐ No
If yes, provide details to include relationship, type of disease, age diagnosed, current age or age and cause of death.

Are you currently taking any medications? If yes, list name, amount, frequency and condition treating. ☐ Yes ☐ No

Please list all medical conditions to include diagnosis, date of onset and recovery, and the name, address and phone number of all attending physicians and hospitals.

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Capitol Metro Financial Services, Inc. (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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, my prescription records and listing of medications prescribed, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

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

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g. a physical exam) is requested solely for the purpose of creating protective health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured's Name	Proposed Insured's Signature
Signed & Dated On	At (City, State, Zip Code)

Agent/Witness Signature: _____

Print Agent/Witness Name: _____

General Agent/Case Manager: _____

Accordia Life & Annuity Company, Allianz Life Insurance Company of North America, American General Life Insurance Company, American National Insurance Company, American National Life Insurance Company of NY, Americo, Ameritas Life Insurance Corp., Ameritas Life Insurance Corp. of NY, Assurity Life Insurance Company, Athene Annuity & Life Company, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Financial, Brighthouse Life Ins. Co., Brighthouse Life Ins. Co. of NY, Columbian Life Insurance Company, Columbian Mutual Life Insurance Company, Companion Life Insurance Company, First Met Investors, Fidelity Security Life, First MetLife Investors, First Symetra National Life Insurance Company of New York, Forethought Life Insurance Company, Global Atlantic, Guardian Life Insurance Company, John Hancock Life Insurance Company (USA), John Hancock Life Insurance Company of NY, Liberty Life Assurance, Life Insurance Co. of the Southwest, LifeSecure Insurance Company, Lincoln Life Insurance & Annuity Co. of NY, Lincoln National Life Insurance Company, Lloyd's of London, MetLife Investors USA, Metropolitan Life Insurance Company, Minnesota Life Insurance Company, Mutual of Omaha, National Guardian Life, National Life Insurance Company, Nationwide Life Insurance Company, New York Life, North American Co. for Life & Health, OneAmerica/State Life Insurance Co., Penn Mutual Life Insurance Company, Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life & Annuity Insurance Company, Protective Life Insurance Company, Prudential Life Insurance Company, Securian Life Insurance Company, Security Mutual Life Insurance Company of NY, Symetra Life Insurance Company, Transamerica Financial Life Insurance Company, Transamerica Life Insurance Company, United of Omaha Life Insurance Company, United States Life Insurance Company of New York, Vantis, Voya ReliaStar Life Insurance Company, Voya ReliaStar Insurance Company of New York, Voya Security Life of Denver, Western-Southern Life Assurance Company, William Penn Life Insurance Company of NY

HIPAA Authorization for Release of Health-Related Information
This authorization complies with the HIPAA Privacy Rule

Name(s) of Proposed Insured/Patient | Date(s) of Birth

_____ _____

_____ _____

Name(s) of unemancipated minors | Date(s) of Birth

_____ _____

_____ _____

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to me or on my behalf or to or on the behalf of my unemancipated minor children ("My Providers") to disclose the entire medical record and any other protected health information concerning me or my unemancipated minor children to the company(ies) referenced on this authorization ("the Company(ies") 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.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information or that of my unemancipated minor children do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by § 164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 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 for revocation to the Company(ies) at 7230 Lee DeForest Drive, Suite 105, Columbia, MD 21046, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company(ies) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record or that of my unemancipated minor children, the Company(ies) may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Primary Proposed Insured/Patient or Personal Representative | Date

_____ _____

Signature of Secondary Proposed Insured/Patient or Personal Representative | Date

_____

Description of Personal Representative's Authority or Relationship to Patient

Last 4 digits of SSN of Primary Insured/Patient_____ Last 4 digits of SSN of Secondary Insured/Patient_____

Address_____ Address_____

Policy or contract number (if known)_____ Policy or contract number (if known)_____