Tower Financial Planning Associates, INC.

1020 Laurel Oak Rd
Voorhees, NJ 08043
Suite 301
Phone: 856-627-1126
Fax: 856-627-1127

PRELIMINARY APPLICATION

Please use (1) application per insured

Agent's Name: ______________________________

Personal Data

Name of Insured: ______________________ e-mail: ______________________

Address: ______________________________

City/State/Zip: ______________________________

Phone: ______________ Date of Birth: __________ Height/Weight ______________

Tobacco Use: Yes ( ) No ( ) Type: ______________ Frequency: ______________

Applying for: Survivorship ( ) Individual ( ) Disability ( ) LTC ( ) Term ( ) Permanent ( )

Coverage Amount: ______________________________

Medical History

Personal Physician: ______________________ Phone: ______________

Address: ______________________________

City/State/Zip: ______________________________

Date & Reason for last visit: ______________________________

Name of other physicians and/or medical facilities that you have seen in the past (5) years:

Personal Physician: ______________________ Phone: ______________

Address: ______________________________

City/State/Zip: ______________________________

Date & Reason for last visit: ______________________________

Personal Physician: ______________________ Phone: ______________

Address: ______________________________

City/State/Zip: ______________________________

Date & Reason for last visit: ______________________________

Please provide any additional information regarding health issues and/or current medications: ______________________

HIPAA Compliant Authorization for Release of Information

I (Patient/Insured) ______________________________ authorize ___________________________________ and/or any licensed physician, healthcare professional, hospital, clinic, laboratory, medical facility, insurance company, Medical Information Bureau (MIB), or any other organization, institution or person that has any records or knowledge of me or my health within the past 10 years, including my entire medical records and any other information protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to disclose such information, including my entire medical records and any other protected health information concerning me to Tower Financial Planning Associates, Inc., as well as the aforementioned life insurance companies and their reinsurers, when necessary. 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 or 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 do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility or healthcare provider to release and disclose my entire medical records without restriction. I understand that upon disclosure to any person or organization that is not a health plan or healthcare provider, the information may not longer be protected by federal privacy regulations.

This authorization shall remain in force for 36 months following the date of my signature below, *and that a photocopy or facsimile of this authorization has the full force and effect as the original.* I understand that I have the right to revoke this authorization in writing, at anytime by sending a written request for revocation to Tower Financial Planning Associates Inc., 1020 laurel Oak Rd. Suite 301, Voorhees, NJ 08043. I understand that a revocation does not apply to information that has already been released in response to this authorization.

I also acknowledge receipt of the notices required by the Fair Credit Reporting Act, which are printed below this authorization. I have been informed of my right to receive a copy of this authorization. I am aware I may be required to complete another application before coverage can be out into effect.

I reserve the right to request that Tower Financial Planning Associates, INC. release my medical records to me upon receipt of my written authorization to do so. I hereby release Tower Financial Planning Associates Inc. from any liability related to the release of my medical records directly to me.

The Fair Credit Reporting Act Notification

In compliance with the Public Law 90-508 (Fair Credit Reporting Act), I understand that part of the underwriting procedure, any life insurance company may secure on me a routine inquiry involving interviews regarding my character, general reputation, personal characteristics, etc. I further understand that upon written request from me, additional information will be provided concerning the nature and scope of such inquiry, if one is actually made.

Patient/Insured Printed Name: ____DOB: ______________________

Patient/Insured Signature: ____Date:______________________

Insurance Company Affiliations

AIG/ American General Life Ins.
American National Insurance Co.
Aviva
Axa Equitable
Banner Life Insurance Co,
Columbus Life
F&G Life Insurance
Genworth Financial Companies
Guardian
Hartford Life & Annuity Co.
ING Companies
John Hancock
Lincoln Benefit Life
Lincoln Financial Group
Minnesota Mutual
MetLife
Mutual of Omaha
Nationwide
New York Life
Pacific Life Insurance Co.
Phoenix Life
Principal Life
Prudential Insurance Co.
Security Mutual
Sun Life Financial
Transamerica Life Insurance
West Coast life
William Penn Life