Submit by Email Print Form

Capital Funding Group

div. of Capital Asset Funding Inc.

Preliminary Application

We will evaluate the information set forth herein. Please complete the following forms and sign where indicated. Please be careful when completing this form. The "Seller" refers to the Owner of the policy the "Insured" is the measuring life under the policy.

1. Personal Data

Name of Seller (i.e. the Owner of the policy)

Social Security #

Current Address:

City: State: Zip:

Telephone Number(s): Daytime ( ) Evening ( )

e-mail

Date of Birth: Sex: ☐ Male ☐ Female Marital Status

Spouses Name

Social Security #:

If Seller is a Trust please provide a list of all Trustees, their addresses and phone numbers:

Trustee #1

Trustee #2

Trustee #3

Seller must attach a copy of the trust agreement and any amendments or addendums thereto.

If Seller is a corporation list the name, title, addresses and phone number of principal officers:
Seller must attach a copy of the relevant corporate documents evidencing your authority to execute the contract on behalf of the corporation.

Has Seller ever been divorced? ☐ Yes ☐ No ☐ N/A

Dependent Children: ☐ Yes ☐ No ☐ N/A

Has Seller ever filed for bankruptcy? ☐ Yes ☐ No If yes, when?

Is Seller currently employed ☐ Yes ☐ No If No, date last worked

If the Insured is not the Owner:

Name of Insured:

Social Security #

Current Address:

City: State: Zip:

Telephone Number(s): Daytime:

Evening:

e-mail

Date of Birth:

2. Life Insurance Policy Information

(Please enclose a copy of your insurance policy with this application)

Name of Insurance Company:

Phone #:

Policy Number:

Death Benefit/Face Amount:

Date Policy was Issued Cash Surrender Value:

Amount of Premium: $

How frequently is premium paid?

Type of Policy: ☐ Term ☐ Whole Life ☐ Universal Life Other ☐

Is this policy Individual or Group

Converted Group

Is this a survivorship policy? ☐ Yes ☐ No

If group policy, please provide the following information:

Name of Organization Providing Coverage:

Name of Benefits Manager or Third Party Administrator:

Address:

Telephone Number: ( ) Fax Number: ( )

e-mail

3. Medical History of Insured

Please give a brief description of medical condition of the Insured:

Name of Attending Physician of Insured:

Name of Insured's Physician:

Address: Telephone: ( )

City State: Zip: Fax: ( )

Insured's Primary or family physician? (If different than above)

Name of Physician:

Address: Telephone: ( )

City: State: Zip: Fax: ( )

If there are any other physicians that have treated the insured in the last three years, you may attach an additional page including their full name, address, and telephone.

Signature of Policy Owner **Printed Name** **Date**

Please attach a copy of your Insurance Policy.

Please attach a copy of the Seller's photo ID issued by State or Local Government.

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Capital Funding Group and/or its authorized representatives or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby expressly authorize such use and disclosure. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

_____	_____	_____	_____
Signature of Insured	Date	Signature of Policy Owner	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date
_____	_____	_____	_____
Signature of Witness	Date	Signature of Witness	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date

PLEASE NOTE: NOT APPLICABLE IN THE STATES OF FLORIDA AND TEXAS.

AUTHORIZATION FOR RELEASE AND USE OF MEDICAL AND/OR INSURANCE INFORMATION

I hereby authorize any physician, medical practitioner, hospice, hospital, clinic or other medical or medically related facility, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer, benefit plan administrator, or any other institution or person to provide Capital Funding Group and/or its authorized representatives or designees, any and all information as to diagnosis, treatment and prognosis with respect to any physical or mental condition including psychiatric conditions, or drug or alcohol abuse, of or relating to the Insured.

This authorization allows for the disclosure, inspection and copying of any and all records, reports, and/or documents, including any underlying data, regarding the care and treatment of the Insured, and any other information in your possession concerning any treatment or hospitalization, including, but not limited to, all testing materials completed by or administered to the Insured, along with any and all medical charts, clinical or doctors' notes, memoranda, medical reports, X-ray reports, index cards, history notes, pictures, records and medical bills in your possession and control.

I understand that the information authorized for release may also include insurance policy information, including but not limited to, forms, riders and amendments concerning the policy. I understand that funding sources and their medical underwriters and/or contingency re-insurers will use information released or obtained pursuant to this Authorization for the purposes of pursuing and/or completing the sale of life insurance policy(ies) on which I am the owner or Insured, and I hereby expressly authorize such use and disclosure. I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the life time of the undersigned (or the last to survive of the undersigned if more than one signatory), absent any provision of any applicable state statute or regulation to the contrary, in which event it shall remain valid for the maximum period permitted thereunder.

_____	_____	_____	_____
Signature of Insured	Date	Signature of Viator	Date
_____	_____	_____	_____
Printed Name	Date	Printed Name	Date
_____	_____	_____	_____
Signature of Witness	Date	Signature of Witness	Date