Capital Wealth Advisors

HIPAA / MVR AUTHORIZATION

AUTHORIZATION TO OBTAIN AND DISCLOSE CONFIDENTIAL MEDICAL INFORMATION & MOTOR VEHICLE RECORD INFORMATION

Proposed Insured: _____

Date of Birth: _____ **Social Security Number:** _____

Medical Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Capital Wealth Advisors, and brokers, contractors, employees, representatives and agents working for or through Capital Wealth Advisors for purposes of the Proposed Insured applying for or evaluating insurance coverage.

Capital Wealth Advisors may also obtain and share as aforementioned Motor Vehicle Record information on the clients behalf for the purposes of the Proposed Insured applying for or evaluating insurance coverage.

INSURED AND AGENCIES

21st Service	Cleveland Clinic	Lincoln Benefit Life Company	Principal Life
5 Brokerage	Columbus Life	Lincoln Financial Companies	Protective Life
Accorida Life	Coventry First, LLC	Living Life Insurance Services	Prudential Life Insurance Co's.
Advanced Services	Credit Suisse Group	Lloyds of London	RSA Medical
Advanced Underwriting Solutions	Crump Insurance Services, Inc.	Magna Life Solutions	Security Mutual
Agency One	Cundy, Inc.	Mass Mutual	South Cap
AIG	EMSI	MediConnect	State Life Insurance Co.
Allianz	Express Imaging Services	Metropolitan Life Insurance Co.	Sun Life Insurance Co, US
American General Life Insurance Co.	Fasano Associates, Inc.	Minnesota Life	Symetra
American National (ANICO)	Fidelity & Guaranty Life Insruance Co.	National Life Insurance Co.	The Leaders Group, Inc.
APPS Paramedical	Genworth Life Insurance Co.	National Life of Vermont	Transamerica Life Insurance
Ashar Group, LLC	Global Financial Advisory	Nationwide Financial	Travelers Life Insurance Co.
Ash Brokerage	Goldman Sachs Bank, USA	New England Life Insurance Co.	Union Central Life
Athene Life & Annuity	Guardian	New York Life & Ins. & Annuity Co.	United of Omaha
AVS	Hanleigh General Agency, Inc.	North American Company	US Life Insurance Co.
AUS	Indianapolis Life	Ohio National	Voya - Reliastar Life Insurance Co.
AXA Equitable	Jackson National	Pacific Life & Annuity Co.	Voya - Security Life of Denver Co's.
Banner Life	John Hancock Life Insurance Co.	Pacific Life Insurance Co.	West Coast Life
Bell & Associates	Kestler Financial Group	Peachtree Life Settlements	World Wide Inspections
Calusa River Capital, LLC	Lewis & Ellis, Inc.	Penn Mutual	Zurich America Life
Capital Settlements	Liberty Life Assurance Co. of Boston	Petersen International Underwriters	
Capital Management Services, Inc.	Life Equity, LLC	Phoenix Life Insurance Co.	
Capital Wealth Advisors / CWA Adv. Svcs.	Life Insurance Co. of the Southwest	Portamedic	

Authorization

Per HIPAA regulations, the purpose of this Authorization is to determine my eligibility and assist in placement of my application for insurance products and services from the life insurance companies listed above. I hereby authorize the release of any and all records and information regarding me, the proposed insured, pursuant to this Authorization. This includes any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition. Such records and information may include, but are not limited to, facts about my: (1) mental and physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing and treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing and treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I hereby authorize any medical practitioner, any medical facility; and laboratory; any other medical entity; any insurer; any financial institution; my employer; and any consumer reporting agency to give the information described above to the companies listed above.

I also hereby authorize any representative of Capital Wealth Advisors to obtain and distribute details regarding my motor vehicle record on my behalf, and authorize any state representative to provide the requested information to the Capital Wealth Advisors representative.

Those parties named above may disclose the information that they have collected about me for the purposes referenced herein only. They may disclose this information to (1) other insurers to which I have applied or may apply, (2) reinsurers; or (3) other persons who perform business, professional or insurance services for them. This includes life settlement companies for the purpose of selling a current life insurance policy. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed above may use the secured internet-based system called "UConnect" to store and/or access some or all of the confidential and personal information.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to the redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 36 months from the date of my signature below. I understand that I may refuse to sign this authorization but that if I do refuse to sign, the companies listed above may not be able to fulfill the purpose of this authorization. I understand that I may revoke this authorization at any time by writing to 9130 Galleria Court, Third Foor, Naples, FL 34109; however, any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

A photocopy of this Authorization is valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Insured(s).

Signed at _____ this _____ day of _____, (year) _____

Signature of Proposed Insured / Guardian or Custodian / Authorized Representative:

X _____

If signed by the Authorized Representative of Proposed Insured, describe authority or relationship to proposed insured (e.g. parent of minor child, guardian, conservator, etc.)

Signature of Witness: _____

Signature of Policy Owner(s) (not required) _____

Complete if Minor Child is proposed for Coverage:

Name of Minor Child:_____ Relationship of Representative to Minor: _____

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE

Capital Wealth Advisors

INFORMAL INQUIRY

Client Information

NAME	DOB	❑ M	❑ F
PLACE OF BIRTH (CITY & STATE)	HEIGHT	WEIGHT	SSN
DATE OF LAST NICOTINE USE	TOBACCO TYPE	HOW OFTEN?	
PRIMARY ADDRESS			
CITY	STATE	ZIP	COUNTRY
CONTACT PHONE	EMAIL ADDRESS		
INSURANCE AMOUNT	PLAN OF INSURANCE		

Medical History- Please supply details of "Yes" answers in space below.

As far as you know, within the last 10 years have you had:	Yes*	No
a) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, or any other disorder of the heart or blood vessels?	❑	❑
b) Diabetes, elevated blood sugars, glucose intolerance, or disease of any gland?	❑	❑
c) Mental or emotional disorder, depression, nervous breakdown, convulsions, epilepsy paralysis or any other disorder of the brain or nervous system?	❑	❑
d) Arthritis, gout, or any bone, joint, muscle, skin disorder or skin cancers?	❑	❑
e) Asthma, bronchitis, pneumonia, emphysema, or any lung disorder?	❑	❑
f) Hepatitis, ulcer, colitis, or other disease of the liver, pancreas, stomach or bowel/colon?	❑	❑
g) MALES: Prostate or testicular, or FEMALES: Uterine, cervix, ovary, or breast disease?	❑	❑
h) Anemia, leukemia, clotting disorder, platelet or other blood disorder?	❑	❑
i) Urinary tract disorder, kidney, sugar, protein or blood in urine?	❑	❑
j) Cancer or tumors?	❑	❑
k) Any HOSPITAL admission, surgery, or EMERGENCY ROOM visit or outpatient surgery?	❑	❑
l) Any other health impairment or medical condition related to this risk evaluation?	❑	❑
Other	**Yes***	**No**
a) FEMALES: Are you currently pregnant?	❑	❑

*Details of "Yes" answers (please attach additional page(s) if necessary):

Medication - Please list all prescription, over the counter drugs, and vitamins:

Family History

Have any immediate family members (parents, brothers, sisters) died prior to age 60? Yes ❑ No ❑

If yes, please identify family member, cause of and age at death:

Financial Information

NET WORTH	TOTAL AMOUNT OF INSURANCE INFORCE

Special Risk

Avocation or special risk concerns (flying, diving, planned foreign travel, extreme sports etc.)? Yes ❑ No ❑

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DOCTOR'S LIST

Please list all doctors the Insured has seen in the last five year.

Primary Care Physician			
NAME			DATE LAST SEEN
ADDRESS			
CITY	STATE	ZIP	PHONE #
Specialist			
NAME			TYPE OF DOCTOR
ADDRESS			
CITY	STATE	ZIP	PHONE #
Specialist			
NAME			TYPE OF DOCTOR
ADDRESS			
CITY	STATE	ZIP	PHONE #
Specialist			
NAME			TYPE OF DOCTOR
ADDRESS			
CITY	STATE	ZIP	PHONE #
Specialist			
NAME			TYPE OF DOCTOR
ADDRESS			
CITY	STATE	ZIP	PHONE #
Additional physicians/specialists or institutions:			

NOTICE TO PROPOSED INSURED

Federal Fair Credit Reporting Act

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources or others with whom you are acquainted. This report includes information as to your character, general reputation, personal characteristics and mode of living. Upon written request to the life insurance companies listed in this Notice, within reasonable time after receipt of the Notice, you will be informed whether or not an investigative consumer report was requested. If so, you will be advised of the name, address and telephone number of the consumer reporting agency to which the request was made. The consumer reporting agency, upon request, will furnish information as to the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

MIB (Medical Information Bureau) Disclosure

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this notice or their re-insurers may however make a brief report thereon to the Medical Information Bureau, Inc. This is a non-profit membership organization of life insurance companies which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or heath insurance coverage, or claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of this request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02122 Tel. (617) 426-3660. The companies listed in this Notice or their re-insurers may also release information in their files to the other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely primarily on information provided by you. The companies may also seek information from others, such as medical professions who have treated you. In some cases, the insurance companies may ask a consumer reporting agency to collect information and submit an investigative consumer report to them as explained in this Notice under Federal Fair Credit Reporting Act. You may request to be interviewed in connection with the preparation of this report. In Certain Limited situations, the insurance companies are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. **The above is a general description of the listed insurance companies, and your agent's information practices. If you would like to receive a more detailed explanation of these practices, please send your requests to: Capital Wealth Advisors Attn: Underwriting Department Supervisor, 9130 Galleria Court, Third Floor, Naples, FL 34109.**

Capital Wealth Advisors acts as broker for the following listed insurance companies:

AIG Life Insurance Company
Allianz
American General Life Insurance Companies
American General Life Insurance Company of New York
American National (ANICO)
AmerUS Life Insurance Company
AXA Equitable
Aviva
Banner Life
Genworth Life Insurance Company
Hartford Life Insurance Company
Indianapolis Life Insurance Company
ING - Reliastar
John Hancock Financial Services
Life Insurance Company of the Southwest
Lincoln Benefit Life Insurance Company
Lincoln Life Insurance Company
Metropolitan Life Insurance Company
National Life of Vermont
Nationwide Life Insurance Company
North American Company for Life and Health
Ohio National
Pacific Life
Penn Mutual
Phoenix Home Life
Principal Life
Protective Life Insurance Company
Prudential Life Insurance Company
Security Connecticut
Security Life of Denver Insurance Company
Security Mutual Life Insurance Company
Sun Life Financial
Transamerica
Union Central
United of Omaha Life Insurance Company
United States Life Insurance Company in the City of New York

Capital Wealth Advisors

LIFESTYLE- HEALTH CREDIT WORKSHEET

IMPORTANT: Answers can GREATLY IMPACT underwriting.

Proposed Insured: _____ Date of Birth: _____

General Information

a) Are you married? Yes ❑ No ❑

b) Highest level of Education? _____

Diet

Do you adhere to any specific diet? Briefly describe.

Exercise

Do you exercise? What do you do and how often?

Health

Do you obtain routine medical, dental and vision screenings? Please describe.

Social

a) Are you currently employed? Yes ❑ No ❑ If yes, what is your occupation? _____

b) If retired, what did you do before retirement? Briefly describe.

d) What are some of your hobbies and interests? _____

e) Are you active in any clubs, church, volunteer groups, boards, charities? Please describe.

Travel

a) Do you travel? How often? Business/Pleasure? International? Countries? Future plans? Please describe.

b) Have you had any motor vehicle infractions/accidents in the last 5 years? Please describe.

Over-the Counter Supplements: Baby Aspirin Daily ❑ Fish Oil ❑ Vitamins ❑

Any other supplements? _____

NOTICE REGARDING INSURANCE PRODUCTS OFFERED BY AFFILIATED INSURANCE FIRMS

This notice is being provided to you as a client of CWA Asset Management Group, LLC d/b/a Capital Wealth Advisors ("*CWA AMG*"). You have expressed an interest in purchasing certain insurance products from either **[5th Avenue Brokerage, LLC or Capital Wealth Advisors, Inc.]**, each an insurance firm that is owned by CWA AMG principals (an "*Affiliated Insurance Firm*"). As noted in CWA AMG's Form ADV, Part 2A, investment adviser representatives of CWA AMG, in their capacity as insurance agents of the Affiliated Insurance Firms, may offer clients insurance and other products for which they are entitled to receive commissions or other remuneration. This creates a conflict of interest that may affect the judgment of these investment adviser representatives when making recommendations to clients; however, CWA AMG's Code of Ethics prohibits CWA AMG personnel from putting their interests ahead of the interests of clients.

By your signature below, you acknowledge your understanding that: (i) CWA AMG personnel have a financial interest in insurance products that may be offered to you through an Affiliated Insurance Firm; and (ii) you are not required to use any insurance services offered by CWA AMG personnel through an Affiliated Insurance Firm.

Client Printed Name: _____

Client Signature: _____

Date: _____