Life Policy Review

CLIENT INFORMATION

Name _____ Date of Birth _____

Marital Status _____ Number of Children _____

RECENT LIFESTYLE AND FAMILY CHANGES

Are you recently married, divorced, or widowed? _____

Any changes in income including salary or inheritance? _____

Do you need to fund retirement or college education? _____

Did you purchase or sell a home? _____

Have any children been added to or left the household? _____

Are you caring for a special needs child? _____

Are you the caretaker of a parent or relative? _____

LIFE INSURANCE POLICY INFORMATION

Do you currently own any life insurance policies? _____ If yes, when was your last review? _____

When were they purchased? _____

Why was this coverage purchased? _____

Has your health changed since the purchase? _____

Were you a smoker? _____ If yes, have you recently stopped? _____

NEED ANALYSIS

Collect the following information and visit LifeHappens.org to calculate the need for life insurance.

Final Expense Costs _____

Outstanding Mortgage _____

Other Outstanding Debts _____

Current retirement savings _____

Current all other savings

Ongoing annual income for spouse & dependents _____

Spouse's Annual Income _____

Estimated Inflation Rate _____

Children Requiring College Funding

Child 1 Current Age _____ Public or Private

Child 2 Current Age _____ Public or Private

Child 3 Current Age _____ Public or Private

Child 4 Current Age _____ Public or Private

For how many years? _____

For how many years? _____ Spouse's marginal tax rate? _____

After-tax net investment yield _____

LIFE POLICY DETAILS

POLICY 1

Insurance Company _____ Face Amount _____

Policy Type: ☐ ____ Year Level Term ☐ Whole Life ☐ Universal Life ☐ Variable UL

☐ Other: _____

Purpose of insurance _____

Annual Premium amount _____ Issue Date _____

Surrender Penalty Amount _____ Policy Cash Value _____

Policy Owner _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Insured Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Beneficiary Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

POLICY 2

Insurance Company _____ Face Amount _____

Policy Type: ☐ ____ Year Level Term ☐ Whole Life ☐ Universal Life ☐ Variable UL

☐ Other: _____

Purpose of insurance _____

Annual Premium amount _____ Issue Date _____

Surrender Penalty Amount _____ Policy Cash Value _____

Policy Owner _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Insured Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Beneficiary Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

POLICY 3

Insurance Company _____ Face Amount _____

Policy Type: ☐ ____ Year Level Term ☐ Whole Life ☐ Universal Life ☐ Variable UL

☐ Other: _____

Purpose of insurance _____

Annual Premium amount _____ Issue Date _____

Surrender Penalty Amount _____ Policy Cash Value _____

Policy Owner _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Insured Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Beneficiary Name _____ Relationship to you ☐ Self ☐ Spouse ☐ Other _____

Comprehensive Medical Questionnaire

Considerations:

- ☐ Minimum Term Face amount is $2,500,000
- ☐ Minimum Permanent Face amount is $1,000,000
- ☐ Minimum Anticipated Premium is $5,000 - $10,000+

Client Information:

Full Name: _____

Date of Birth:_____ SSN:_____ ☐ Male ☑ Female

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone Number: _____

Plan of Insurance Requested:

Individual: ☐ Term ☐ UL ☐ IUL ☐ VUL ☐ WL **Survivorship:** ☐ SUL ☐ SVUL

New Coverage Amount Requested: $ _____

In-Force Life Coverage Amount: $ _____

Nicotine Use (any tobacco use within the last five years):

- ☐ None
- ☐ Cigarettes How much and how often? _____
- ☐ Cigars How much and how often? _____
- ☐ Chewing Tobacco How much and how often? _____
- ☐ Nicotine Gum/Patch How much and how often? _____
- ☐ Other: _____ How much and how often? _____

If you have used any of the above products, when did you stop using them?

_____

Health Conditions & Physician Information: Please list any health conditions that you currently seek medical treatment for, including as much detail as possible regarding the date of diagnosis and treatment. For example: high blood pressure, sleep apnea, diabetes, etc.

Approximate Height: _____ Approximate Weight: _____

Personal Physician Name: _____

Physician City & State: _____

Physician Phone Number: _____ Last Visit Date: _____

Reason for Visit:

_____

_____

Health Conditions:

_____

_____

_____

_____

_____

Other Medical Specialists? Please list all:

_____

_____

Medications:

Are you currently taking any medications? Please list the type, diagnosis, dosage and/or frequency.

_____

_____

_____

_____

_____

Family Medical History:

Do you have any family history (parent or sibling) of cardiovascular disease, cerebrovascular disease, diabetes or cancer prior to age 60? ☐ Yes ☐ No

If yes, provide full details with impairment, age at onset and age at death if deceased:

Father: _____

Mother: _____

Siblings: _____

Wealth Preservation & Management
311 Main Street, Irwin, PA 15642
Phone 800-517-9901 | Fax 828-476-4501

HIPAA Authorization to Release Information

PROPOSED INSURED INFORMATION

Proposed Insured/Patient Name _____Date of Birth_____SSN_____

This will authorize _____(*Physician, Clinic or Hospital Name*) to release medical information to Wealth Preservation and Management and its affiliated agencies.

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Wealth Preservation & Management and its affiliated agencies to disclose my personal financial and health information to the insurance companies listed below.

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 my 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 history of medication prescribed.

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 Wealth Preservation & Management. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed 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 below and their re-insurers as well as Wealth Preservation & Management and its staff, employees and affiliated companies. In addition, I also authorize the entire contents of the medical file compiled by the carrier, including but not limited to para-medical exam information, lab results, lab ticket documentation, medical records, applications, any and all medical correspondence and the like, to be released to Wealth Preservation & Management and its staff.

This authorization shall be valid for twelve (12) 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 my Representative to revoke this authorization and that the revocation will take effect when my 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 understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Wealth Preservation & Management 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 Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

Proposed Insured/Patient Signature_____Date_____

_____

Agent's Signature | Agent's Name (Please Print) | City and State | Date

Accordia Life, Allianz Life Insurance Company of North America, American General Life Insurance Company, American National Insurance Companies, Americo Financial Life & Annuity Insurance Company, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Life Insurance Company, Cincinnati Life, Companion Life Insurance Company, EMC National Life, Fidelity Life, ForeThought, Genworth Financial Family of Companies, General Re Life Corp, Guardian Life Insurance Company, Hannover Re, John Hancock, LifeMark Partners, Lincoln National Life Insurance Company, MassMutual, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Minnesota Life insurance Company, Munich Re, Mutual of Omaha, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, OneAmerica, Pacific Life Insurance Company, Penn Mutual Life Insurance Company, Principal Financial Group®, Principal Life Insurance, Principal National, Principal National Life, Protective, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, RGA Re, Sagicor, Savings Bank Life Insurance Company of Massachusetts, SCOR, Security Life of Denver Insurance Company, The Standard, Sun Life Assurance Company of Canada, Swiss Re, Symetra Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, VOYA Life, William Penn Life Insurance Company of New York REV 11/2017

Authorization for Disclosure of Information – Life Insurance Policies

General Information (Please type or print clearly.) **All sections must be completed.**

Policy Number:_____ Issuing Insurance Company:_____

Additional Policy Numbers:_____

Insured Information

Full Legal Name *(First, Middle, Last)*: _____

Insured's Mailing Address:_____

City: _____ State: _____ Zip:_____

Social Security Number: _____ Date of Birth: _____

Daytime Telephone Number:_____

Owner Information (If different from insured)

Full Legal Name *(First, Middle, Last or Trust/Corporation Name)*: _____

Owner's Mailing Address: _____

City: _____ State: _____ Zip:_____

Social Security Number / EIN: _____ Date of Birth / Trust: _____

Daytime Telephone Number:_____

Representative Information

1. I (the undersigned) am the owner of the life insurance policy identified above. By this form, I am authorizing you to share information on the above-referenced policy with the authorized representative/s listed below. This form grants the authorized representative/s the authority to obtain and/or request information regarding my existing life insurance. Such information includes, but is not limited to:
   - Personal information: including, but not limited to, names, addresses, Social Security numbers, financial and employment history.
   - Information about transactions with the company : such as products purchased, account balances, payment history, policy changes, beneficiary designations, loan history.
   - Information collected from consumer reporting agencies: such as credit history, credit scores, driving or employment records.
   - Policy Information: Policy values (Face Amount, Death Benefit, Cash Values, Loan Values), inforce illustrations, current policy summaries, historical statements.

   Name of Authorized Representative/s *(First, Middle, Last)*:_____

   Mailing Address: _____

   City: _____ State: _____ Zip:_____

Authorizations and Signatures

I certify that the information provided on this form is complete and correct.

_____ _____

Owner/Trustee Signature Date Joint Owner/Trustee Signature Date

_____ _____

Owner/Trustee Printed Name Joint Owner/Trustee Printed Name

_____ _____

Authorized Representative Signature Date Printed Name