BUA

A Division of Specialty Program Group, LLC

FIRST PLACE

PRELIMINARY UNDERWRITING INQUIRY

THE BEST OFFERS
FROM THE BEST CARRIERS
AT THE BEST PRICE
THE FIRST TIME

3600 Embassy Parkway
Suite 100
Akron, OH 44333
800.792.6795

www.buaweb.com

Underwriting is the most important aspect of product pricing in the insurance industry. Put BUA's experience to work for your client.

Complete the First Place Preliminary underwriting Inquiry and set yourself apart from the competition.

Our In-House Underwriter will review the facts and shop your case for the best possible offers. Medical records may be ordered on cases with an annual premium over $5,000.

A few minutes today can save you and your clients time and money.

UNDERWRITING. UNDERSTOOD.

This is not an application for life insurance

First Place Preliminary Underwriting Inquiry

This First Place Preliminary Underwriting Inquiry form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Proposed Insured's Signature _____

Personal Information

Name _____ □ Male □ Female Soc. Sec. # _____
Address _____City_____State_____Zip _____
Date of Birth_____ U.S. Citizen? □ Yes □ No
If no, country of citizenship and type of VISA_____Date entered into U.S.?_____
Occupation _____ Annual Income $_____ Net Worth $ _____

Have you recently applied for insurance? □ Yes □ No
If yes, type of insurance, underwriting decision, and reason?
_____

Provide details on pending and in-force coverage:

Company	Policy# Or Application	Amount	Class/Rating Issued:	Current Premium	Date issued	Do you intend to replace?
						Y / N
						Y / N
						Y / N

Plan of Insurance

□ Universal Life □ Whole Life □ Index UL □ Variable Life □ Term, Level Period _____
□ Survivorship *Please have other proposed insured submit First Place as well*
□ Annuity □ LTC
□ Disability Income: Monthly Benefit Amount_____ Elimination Period: □ 30 days □ 60 □ 90 □ 180
Benefit Period: □ 2 year □ 5 year □ 10 year □ Age 65/67 Exclusions: _____

Face amount desired: $_____ Premium amount desired: $_____ □ Annually □ Monthly

If you are replacing coverage, will there be any 1035 money with this replacement? □ Yes □ No
If yes, Gross 1035 $ _____ Loan, if any $ _____ Basis $ _____

What is the purpose of this coverage? *Check all that apply*
□ Buy/Sell □ Key Person □ Estate Planning □ Income Replacement □ Charitable Planning
□ Executive Benefits □Other _____

Who is to be primary beneficiary? _____ Relationship: _____
Contingent beneficiary? _____ Relationship: _____
Owner? _____ Payor? _____

Medical History

1. Height: ____Weight: _____ If you have lost any weight this year, amount and reason: _____

2. Have you ever used tobacco or any other nicotine products? □ Yes □ No
   If yes, in what form? _____ Date of last usage: _____
   If cigars, how many per year? _____

3. Have you been convicted of a DUI and/or had or more then 1 moving violation in the past 3 years? □ Yes □ No
   If yes, please give the type and date(s) of violations

4. Please list all current medications and frequency.

   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____
   _____ _____ _____

5. Who is your primary care physician? _____
Address _____ Phone _____
Date of last visit: _____ Reason: _____

6. What other physicians have you consulted during the past five years and why? Please also provide name and address of facility and date of last visit.

   _____ _____
   _____ _____
   _____ _____
   _____

7. Has any parent or sibling been diagnosed with heart disease, stroke, cancer, polycystic kidney disease or Huntington's disease?
   □ Yes □ No

Relation to Insured	Disease	Age at Onset	Age (if Living)	Age at Death

8. Do you currently drink alcohol? □ Yes □ No
   If yes, date last used?_____ Amount per week?_____
   Have you ever consulted a doctor or received treatment because of your alcohol use? □ Yes □ No
   If yes, please provide date(s): _____
   Are you an active member of a support group such as AA? □ Yes □ No
   Have you ever had a relapse? □ Yes □ No If so, when? _____

9. Have you ever used illegal drugs or used prescription drugs other than prescribed? □ Yes □ No
   Name of drug(s): _____
   Date of last use: _____
   Have you ever sought treatment for drug use? □ Yes □ No - ***If Yes,*** where and when?_____
   _____

Are you an active member of a support group? □ Yes □ No

Have you ever had a relapse? □ Yes □ No If so, when? _____

If any questions are answered YES in this section, please reach out to us for a Supplemental Questionnaire

10. Have you ever been diagnosed with coronary artery disease, or had a heart vessel bypass/stent? □ Yes □ No

Name of cardiologist or physician treating and date last seen:_____

Date of diagnosis: _____Number of diseased vessels: _____

Which vessels, if known: _____Were you treated surgically? □ Yes □ No

If yes, when? _____

Check the procedure(s) you had:

□ Angioplasty with stenting (how many?) _____ □ Bypass (how many?)_____

Date of last cardiac testing: _____Results: _____

Any chest pain since treatment/surgery? □ Yes □ No

11. Have you ever been diagnosed with sleep apnea? □ Yes □ No

Date of diagnosis: _____ Severity: _____ Date of last sleep study: _____

Treatment_____ If CPAP or BIPAP, do you use regularly? Y/N

12. Have you ever had cancer or a tumor? □ Yes □ No

Exact name and location of cancer or tumor: _____

Stage and grade: _____

Who would have the pathology report?_____

Dates of treatment/surgery: _____

Any recurrence? _____

Do you have at least an annual follow-up? □ Yes □ No With whom? _____

13. Have you ever been diagnosed with diabetes? □ Yes □ No

If yes, check which type: □ Type I □ Type II □ gestational diabetes

Date of diagnosis: _____

Treatment (check all that apply): □ Diet Only □ Oral Medication □ Insulin

What was your last hemoglobin A1c level? _____

Please check any and all complications you've had related to your diabetes:

□ eye trouble □ kidney trouble □ neuropathy/extremity pain □ hospitalizations □ ulcers

14. Please check any/all of the following impairments with which you have been diagnosed and provide details:

□ **Cardiovascular:** hypertension, stroke, TIA, carotid disease, peripheral vascular disease, heart valve disorder, abnormal heart rhythm, cardiomyopathy, or any other cardiovascular disease not listed

□ **Gastrointestinal:** esophagus, stomach, colon, liver, pancreas, other gastrointestinal disease not listed

□ **Pulmonary**: asthma, COPD, emphysema, sarcoidosis, other pulmonary disease not listed

□ **Mental/nervous:** depression, anxiety, bipolar, ADD, fainting, seizures, brain tumor, multiple sclerosis, other

□ **Musculoskeletal:** osteoarthritis, rheumatoid arthritis, lupus, connective tissue disorder, chronic pain, back disorder, other musculoskeletal disease not listed.

□ **Any disorder of:** kidney, urinary tract, blood or circulatory system, immune system, reproductive system, skin, eye, ear, any disorder not otherwise specified.

14. *continued* Details to include:

_____

_____

_____

_____

_____

15. Do you:

□ Participate in regular aerobic exercise
□ Follow a healthy diet
□ Have age-appropriate screening tests with normal results (mammogram, colonoscopy, etc)
□ Have regular checkups with your physician
□ Have normal blood pressure and cholesterol levels? If so, please list, if known
Blood pressure _____ Total cholesterol _____ Cholesterol/ HDL ratio _____

Nonmedical History

1. Are you now or have you ever been a pilot or a crew member on a plane or helicopter? □Yes □No
If yes, type of aircraft: _____ Private or commercial? _____
How many hours do you fly per year? _____ Number of solo hours flown _____
Do you have an IFR (instrument flight rating)? □Yes □No Have you ever been grounded? □Yes □No

2. Please check any and all of the activities in which you've participated in the last five years
□ Scuba diving □ Bungee jumping □ Sky Diving □ Mountain Climbing □ Hang Gliding
□ Auto/Motorcycle Racing □ Other
Date of last participation? _____ Are you a member of any sanctioned club? □Yes □No

Additional details: _____
_____
_____

3. Have you ever filed bankruptcy? □Yes □No If yes, what chapter?_____Date of discharge? _____

4. Have you ever been charged with a criminal offense? □Yes □No
If yes, was it a misdemeanor or felony? _____ When were you charged? _____
What was the offense? _____
What was the sentence? _____
Have you completed your obligation to the court? □Yes □No
Have you served a probation sentence? □Yes □No
If yes, are you currently serving? □Yes □No Dates on probation: _____

Additional details: _____
_____
_____

5. Have you traveled to any foreign country in the past two years? □Yes □No
Country/City_____ Purpose_____ Duration _____
Do you have any future plans of foreign travel in the next two years? □Yes □No
Country/City_____ Purpose_____ Duration _____

Agent Information – (this section must be completed)

Name:_____ _____
Phone No.:_____ Fax No.: _____
Address_____City_____State_____Zip _____
Email Address: _____

Business Underwriters Associates, L.L.C.

Authorization to Obtain Information
Waiver and Acknowledgement

I AUTHORIZE (primary care physician name) _____, OR any health physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit managers, medical facility, or other health care provider (My providers) that has provided treatment or services to me or on my behalf to disclose my entire medical record and any other protected health information concerning me to Business Underwriters Associates, LLC and any of its affiliates, 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 signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical records without restriction.

I UNDERSTAND my protected health information is to be disclosed under this Authorization so that BUA may: I) underwrite my applications for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain insurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Insurance Companies named below:

Accordia/Global Atlantic
Aetna Life
AGL/USL/AIG
Allianz
Allmerica Financial
American Life & Casualty
American National
Ameritas
Assurity
AXA Life
Banner Life
Brighthouse Financial
Canada Life
Central National
Cincinnati Life
Columbus Life
Companion Life of NY
Corebridge Financial
Equitable Financial Life Insurance Co.
Fidelity & Guaranty
Fidelity Security
Fort Dearborn
Fortis
Genworth Financial
Genworth Life & Annuity
Genworth Life of NY
Gleaner
Illinois Mutual
ING USA Life & Annuity
Integrity Life
IDU, Inc.
Jefferson Pilot
John Hancock
Lafayette Life
Life of the Southwest
Life of Virginia
Life Settlement Alliance
Lincoln Life & Ann. of NY
Lincoln National
Lincoln National Rein. Co.
Manulife
Mass Mutual
Minnesota Life
MONY Life Insurance Co.
Mutual of Omaha
North American
North American of NY
National Guardian
National Integrity
National Life Group
Nationwide
New York Life
Oxford Life Insurance Company
Pacific Life
Petersen International Underwriters
Penn Mutual
Penn Treaty
PFL
Physicians Mutual
Principal Life Insurance
Principal National Life
Protective Life
Provident Mutual
Prudential Ins Company of America/Pruco Life Ins Co
Rumson Capital
Reliance Standard
Securian Financial
Security Life of Denver
Security Mutual Life of NY
The Standard
State Life
Stonestreet Financial
Sun Life/ Keyport
Symetra
Transamerica
United of Omaha
US Life
Voya
Voya of NY
Western Reserve Life
William Penn of NY

Other Insurance Company: _____

This authorization shall remain in force for 24 months. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. I understand my revocation must be in writing and addressed to the attention of the Privacy Official at the above-named facility or BUA, 3600 Embassy Pkwy, Ste 100, Akron, OH 44333. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

At Business Underwriters Associates LLC, protecting your privacy is very important to us. We are strongly committed to safeguarding the information you provide us and to use it responsibly. Because of your commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

COLLECTION OF INFORMATION

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms, and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you.
- Information we receive from non-affiliated third parties, including, but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

DISCLOSURE OF INFORMATION

We will not share nonpublic personal information concerning our potential, current, or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your accounts;
- Your agent or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Business, like banks and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies.

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information.

WAIVER AND ACKNOWLEDGMENT:

This waiver and Acknowledgement (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of BUA, its successors, assigns, shareholders, directors, and employees (collectively "BUA") Applicant acknowledges, understands and agrees as follows:

- that applicant has filed an application with BUA intending to secure life insurance from one or more insurance underwriters.
- that, in the course of applying for life insurance coverage, BUA has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- that BUA will provide that information, or parts of it, to a number of potential insurers and their agents, employees, employees and representatives.
- that BUA maintains, or will maintain, an electronic data interchange (the "interchange") through which certain Authorized underwriters and /or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage by or applying for coverage under insurance through policies issued and serviced by those Underwriters.
- that BUA will use the Interchange to store some or all of the confidential and personal information Applicant has provided to BUA, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- that, even though BUA has in place security measures BUA believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though BUA will continue to upgrade those security measures from time to time as circumstances warrant, BUA can make no guarantee as to BUA's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, pay bypass the security measures protecting the integrity of the Interchange.
- that BUA cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange that information is gathered by an Underwriter.
- that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in BUA's possession and /or stored on the Interchange.
- that Applicant will indemnify BUA for all costs and expenses incurred by BUA or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver.

Your failure to execute this authorization may result in Business Underwriters Associates, LLC being unable to collect information relating to you and therefore unable to assist with pre-underwriting or post-underwriting analysis and recommendations.

Applicant has evidenced his/her acknowledgement, understanding, and agreement with respect to the foregoing by signing this document below.

I **ACKNOWLEDGE** that I have received a copy of this document.
I **AGREE** this form shall be valid for twenty-four months (24) from the date shown below.

Signed on this date: _____ / _____ / _____ City, State: _____

Proposed Insured's Date of Birth: _____ Proposed Insured's Social Security Number _____

X _____ **X** _____

Signature of Proposed Insured/Parent or Guardian Signature of Witness

_____

Printed Name of Proposed Insured/Parent or Guardian