Print Form

UPSTATE
Special Risk Services, Inc.

QUICK FACT-FINDER TOOL

** Completion of a FACT FINDER will accelerate the underwriting process**

Agent Name: _____

Agent Phone Number: _____ E-mail address: _____

Proposed Insureds legal name: _____ Date of birth / age: _____

Plan of Insurance requested:
Individual: ☐ Term ☐ UL ☐ VUL ☐ WL **Survivorship:** ☐ SUL ☐ SVUL ☐ SWL

Rate Class Desired: ☐ Best Rate ☐ Preferred ☐ Standard ☐ Rated: _____

Has this case been discussed or submitted to your BGA on a preliminary, trial, or informal basis? ☐ Yes ☐ No

Client's budget: $ _____

Present Nicotine Use:
☐ None ☐ Cigarettes --- frequency of use per day: _____
☐ Cigars ☐ Pipe ☐ Dip ☐ Chew ☐ Nicotine Gum ☐ Other: _____
Quantity per month: _____

Former Tobacco Use: List each type of tobacco, quantity, and frequency used, and date of last use: _____

Build: Height: _____ Weight: _____

Family History: *(Family History is a consideration for each rate class)*
To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60 due to cardiovascular disease, cerebrovascular disease, diabetes or cancer? ☐ Yes ☐ No

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

☐ Father: _____
☐ Mother: _____
☐ Siblings: _____

Blood Pressure and Cholesterol:

Latest BP reading: _____ Latest total cholesterol: _____ mg Latest cholesterol/HDL ratio: _____

Are you currently taking any medication for blood pressure? ☐ No ☐ Yes , Name of medication: _____

Are you currently taking any medication to lower cholesterol? ☐ No ☐ Yes , Name of medication: _____

Aviation / Avocation:
In the past 5 years have you or do you intend to participate in any of the activities listed?

☐ None ☐ Flying ☐ Racing ☐ Sky Diving ☐ Other

Details: _____

Branch office of and securities offered through LifeMark Securities Corp.
400 West Metro Park
Rochester NY 14623
800-828-4415 or 585-273-8530
Member FINRA/SIPC
Upstate Special Risk Services, Inc. is not affiliated with LifeMark Securities Corp.

UPSTATE
Special Risk Services, Inc.

QUICK FACT-FINDER TOOL

Citizenship/Residency/Travel:

US Citizen? ☐ Yes ☐ No

If no, provide type and expiration date of Visa, green card status, and length of time in USA: _____

_____

Any future plans to live or travel outside the USA? * check with your brokerage General Agency regarding state compliance prior to completing any application (s) ? ☐ No ☐ Yes (provide purpose, cities, countries, frequency and duration: _____

_____

Driving History:
Have you had any of the following motor-vehicle-related incidents in the past 10 years?

☐ Moving violation ☐ Reckless driving ☐ DWI or DUI ☐ License suspension ☐ License revoked

Provide dates, details: _____

Medical History:

Have you ever had, been told you had, or been treated for any of the conditions listed? If yes, check all that apply:

☐ Alcohol abuse
☐ Alzheimers/dementia/cognitive impairment
☐ Asthma
☐ Cancer
☐ Cirrhosis
☐ COPD
☐ Coronary artery or cerebrovascular disease
☐ Crohns disease
☐ Depression/anxiety
☐ Diabetes
☐ Drug abuse
☐ Epilepsy
☐ Heart murmur/valve disease
☐ Hepatitis
☐ Irregular heartbeat/palpitations
☐ Kidney disease
☐ Lupus
☐ Multiple Sclerosis
☐ Peripheral vascular disease
☐ Rheumatoid arthritis
☐ Sleep apnea
☐ Stroke
☐ Other

List dates, diagnosis, details, treatment, plus names, addresses, and phone numbers of all physicians consulted:

_____

_____

_____

_____

_____

_____

_____

UPSTATE
Special Risk Services, Inc.

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Upstate Special Risk Services, Inc. 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, but excludes psychotherapy notes.

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 Upstate Special Risk Services, Inc. stand 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 Upstate Special Risk Services, Inc. and its staff, employees and affiliated companies.

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, Upstate Special Risk Services, Inc. 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's Name	Proposed Insured's Signature
_____	_____
Signed and Dated On	At (City, State, Zip Code)
_____	
Agent/ Witness Signature	