Print Form

UPSTATE
Special Risk Services, Inc.

CONFIDENTIAL TRIAL INQUIRY

SIGNATURE REQUIRED

Return to:
400 West Metro Park
Financial Center
Rochester NY 14623
Fax: 585-273-8540

PERSONAL INFORMATION

Applicant's Name	Gender ◯ M ◯ F	Date of Birth	Social Security #
Address (City, State, Zip Code)			Phone #
Height	Tobacco? ◯ Yes ◯ No	If yes, what type?	
Weight		When last used?	Frequency of Use?

INSURANCE INFORMATION

Type of Insurance Applying for	Amount Desired	State of Issue	Total Amount of Insurance In Force
	Replacement? ◯ Yes ◯ No	Previous Coverage Details (Company; Face Amt; Premium)	

Is applicant negotiating or within the last 6 months negotiated for Life Insurance elsewhere?
(Please give details - Company and Outcome)

MEDICAL INFORMATION

Health Impairment(s)

Medications

Physicians/Hospitals visited in the last 5 years

Physician/Hospital Name		Address & Phone #	Date	Reason for Last Visit
PCP				
Other				
Other				
Other				

Family History - any immediate family member died before age 60? If yes, please provide cause and age at death.

BROKER INFORMATION

Broker's Name	Company Name	
Address	Phone #	Email Address
Fax	Are we in competition? Please give Details	

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INQUIRY
QUESTIONS

PLEASE COMPLETE THE APPLICABLE SECTIONS

APPLICANT NAME: _____ *DATE:* _____

CARDIAC

Condition - Describe in detail		
Date of Condition	Date of last Echocardiogram	Current Physician treating Cardiac
Did you have Angioplasty?	◯ Y ◯ N	If Yes, please indicate the date of last Angioplasty:
Did you have Bypass Surgery?	◯ Y ◯ N	If Yes, Number of Vessels by-passed:
Did you have a Heart Attack?	◯ Y ◯ N	If Yes, please indicate date of Heart Attack:
Additional Tests or Procedures Completed:	Please give dates and results	

DIABETIC

Date of Diabetic Diagnosis	Age at time of Diagnosis	Current Physician treating Diabetes	
Form of Treatment	Insulin ☐ Oral Medication ☐ Diet Only ☐	If Insulin - How many units per day? If Oral - type of medication and daily dosage?	
Date of last FBS (fasting blood sugar) test	Last Glucose Reading	Last A1-C Reading	
Date of last A1-C test	Is Home monitoring being done? ◯ Yes ◯ No		
History of Diabetic Complications (if any)			
High Blood Pressure? ☐ Yes ☐ No	Diabetic Eye Disease? ☐ Yes ☐ No	Heart Disease? ☐ Yes ☐ No	
Kidney Disease? ☐ Yes ☐ No	Neurological Disease? ☐ Yes ☐ No	Other? ☐ Yes ☐ No	
Please explain other or give details to "Yes" answers			

CANCER

Date of Diagnosis	Tumor/Cancer Location	Current Physician treating Cancer	
What Stage?		What Group?	
Pathology diagnosis			
Was there any lymph node involvement? ☐ Yes ☐ No	If Yes, how many lymph nodes?		
Was there any metastasis (spread) to any other organ tissue? ☐ Yes ☐ No	If Yes, please provide details		
What kind of Treatment?	☐ Radiation ☐ Chemotherapy ☐ Oral ☐ Medication Surgery	Date of Last Treatment	

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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

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