THE C.O.R.E. GROUP

CENTERED ON RELATIONSHIP ENHANCEMENT

QUICK QUOTE

Required Forms:
General Medical Information
Physician Information
Medical Profile
HIPAA

Complete All That Apply:
Financial Justification
Hazardous Activities
Foreign Travel/Residence/Citizenship
Aviation
Moral Hazards

6004 Highview Drive · Unit G · Fort Wayne, IN 46818
Toll Free: 800-991-6695 · Fax: 260-482-6082 · quickquote@coregroupusa.com

THE C.O.R.E. GROUP

Quick Quote — General Medical Information

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

General Information

Client: _____ Date of Birth: _____

Height: _____ Weight: _____ ☐ Male ☐ Female

Has the client lost over 10 lbs in last year? ☐ Yes ☐ No Is YES, how much? _____

Does client currently use tobacco in any form (e.g. cigarettes, cigars, chewing tobacco, etc.) ☐ Yes ☐ No

If YES, please specify the form of tobacco and the quantity used: _____

If client no longer uses tobacco in any form, when did client quit? _____

What is the client's current blood pressure? _____

What is the client's cholesterol level? _____ Ratio: _____ HDL: _____ LDL: _____

Insurance Questions

Product Requested: _____ Amount Requested: $ _____

Has the client ever been rated or declined for life insurance? ☐ Yes ☐ No

Specify the company, reason and when prior company action occurred: _____

Anticipated premium range: _____

Is this information being sent to other sources? ☐ Yes ☐ No

Family Medical History

List the client's family medical history including the cause of death prior to age 65, if applicable:

Father: _____

Mother: _____

Brother(s)/Sister(s): _____

_____

Medications

List any medications the client is taking along with the dosage and reason for the prescription:

_____

_____

_____

_____

_____

_____

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Quick Quote **General Medical Information Cont.**

Other Considerations

List other considerations that might affect the underwriting process, such as employment situation, financial history, driving history, moral issues, and/or participation in hazardous activities:

*Please fill out any applicable pages that follow: Hazardous Activities / Moral Hazards / Aviation

Additional Comments

Use this area to make any additional comments or provide more information regarding a specific impaired risk category:

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Quick Quote — Physician Information

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

Please list **ALL** of the physicians the client has seen in the past 5 years; please add an additional sheet if needed.

Primary Physician

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Specialists

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Name: _____

Address: _____

Phone: _____ Reason & Date Last Seen: _____

_____

Please complete the "General Medical" form with every Quick Quote form.

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Quick Quote **Medical Profile**

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

Cardiovascular (Check here if this is not applicable) ☐

Type of impairment(s) (e.g. heart attack, bypass, angioplasty, angina, heart murmur, irregular EKG, etc.):

_____

Date of diagnosis: _____

Type of treatment/surgery (bypass surgery - # of blocked vessels, stent - location):

_____

Detail any recurring or new symptom(s): _____

Date that last symptom(s) occurred: _____

Please list all current medications: _____

Has client had any tests done (e.g. EKG, echocardiogram, treadmill, etc.)? List tests & give results:

_____

Describe any lifestyle changes made by the client since the cardiac event(s) like exercise, dietary change, stopped smoking, etc.: _____

Cancer (Check here if this is not applicable) ☐

Date of Diagnosis: _____ Stage/Grade: _____

Type of cancer (e.g. adenocarcinoma, melanoma, etc.) and location of cancer (e.g. prostate, liver, etc.):

_____

Type of treatment (Surgery, Chemotherapy, Radiation)? _____

Date of last treatment and total # of treatments: _____

Any other treatments or surgeries? _____

Describe any metastasis (spreading through body): _____

_____

Was there any lymph node involvement? _____

Any relapses or recurrences? _____

List any family history of cancer (the nature of the cancer, the relationship to the client, etc).:

_____

NOTE: For all prostate cancer cases, please include the date and results of most recent "PSA" reading as well as "PSA" and Gleason Score at time of diagnosis.

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Quick Quote **Medical Profile Cont.**

Diabetes (Check here if this is not applicable) ☐

Date diagnosed: _____

Does client control diabetes through:

Diet and exercise: _____

Medications (Type/Dosage): _____

Describe any complications with eyes, kidneys, circulation, diabetic coma, protein in urine, etc. (occurrence, treatment, and outcome of treatment): _____

_____

Date & result of last urine test? Any sugar or protein present? If present, is this a chronic finding?

_____

Date of last blood glucose level test (fasting) & A1C: _____

Results: _____

_____

_____

Has the client had an EKG performed in the last 5 years? Any abnormalities? Please explain:

_____

Hypertension (Check here if this is not applicable) ☐

Date diagnosed: _____

Current blood pressure reading: _____

Please list any lifestyle changes since the diagnosis (e.g. exercise, diet, stopped smoking, etc.):

_____

Type of treatment (e.g. diet, weight, salt reduction, medication) - please list all that apply:

_____

How long has client been taking present medication? _____

Any complication factors (such as stroke, cardiac events, diabetes, or kidney conditions)?

_____

_____

List dates of EKG or any other cardiac tests done in the last 5 years and explain noted abnormalities.

_____

Stroke (Check here if this is not applicable) ☐

Age when the stroke (TIA or CVA) occurred: _____ # of occurrences: _____

Is there any residual neurological deficit (ex: speech or mobility)?

_____

Did doctors find the cause? _____

Are there any complicating factors (diabetes, CAD, high BP, tobacco use)?

_____

_____

What were the results of your most recent treadmill? _____

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Quick Quote **Medical Profile Cont.**

Respiratory Disorders & Diseases (Check here if this is not applicable) ☐

Type (e.g. asthma, emphysema, COPD, etc.): _____

Date diagnosed: _____ Is client a smoker? _____

Date of last pulmonary function test and results

_____

If a chest X-ray was performed, what were the results?

_____

Has client ever been hospitalized for this condition? If YES, give details including date(s):

_____

Type of Treatment (e.g. breathing machine, oxygen, medication, etc.):

_____

_____

Does the client have any restrictions on "day-to-day" activities? If YES, please explain:

_____

Sleep Apnea (Check here if this is not applicable) ☐

Date diagnosed: _____ Is client a smoker? _____

Date of initial & most recent sleep study/evaluation: _____

Has the condition been diagnosed as mild, moderate or severe? _____

How is the condition being treated (e.g. CPAP mask, weight loss, surgery, etc.)?

_____

_____

Any ongoing symptoms?

_____

_____

Alcoholism/Drug Abuse (Check here if this is not applicable) ☐

How long has it been since the client last consumed alcohol? _____

Any DUI (or reckless driving)? If yes, how many & dates? _____

_____

Name(s) of drug(s) used: _____

Any illegal drug use? Type, frequency, & date last used?

_____

Does the client attend AA or Narcotic's Anonymous meetings? If yes, how often?:

_____

Has blood profile including liver function and "alcohol marker" been performed by a physician within the last 12 months? If YES, describe results: _____

Please include detailed explanation of any lifestyle changes (including occupation, family structure/support):

_____

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Quick Quote **Medical Profile Cont.**

Elevated Liver Function/Enzymes (Check here if this is not applicable) ☐

Date of last blood test: _____

Results:

GGTP : _____ SGPT : _____

SGOT : _____

Have these results been increasing, decreasing, stable or fluctuating? _____

Does the client currently drink alcohol? _____

If YES, frequency & quantity: _____

Has the client been diagnosed or tested for hepatitis? _____

If YES, describe results (+/-): _____

Has the client ever had a live ultrasound, CT scan, or Liver biopsy completed? _____

If YES, give date and describe results: _____

Current medication(s): _____

Depression & Anxiety (Check here if this is not applicable) ☐

Diagnosed with anxiety, depression, or bipolar? _____

Date of onset & type of treatment (counseling, medications): _____

_____

Current medication(s) & dosages: _____

_____

_____

Any other medical history which complicates this history? _____

_____

Any suicidal attempts/thoughts? If YES, how often? _____

Date of last incident: _____

Duration that client has been under effective control: _____

Current family/occupational "situation": _____

Other (Check here if this is not applicable) ☐

Diagnosis: _____

Date diagnosed: _____

Type of treatment (e.g. lifestyle change, surgery, medication, etc.)? Please list all that apply:

_____

_____

Please list any "special" testing that has been performed, including the dates of the tests and the results:

_____

_____

Has there been any hospitalization? If YES, please give the dates and details:

_____

_____

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CENTERED ON RELATIONSHIP ENHANCEMENT

HIPAA Authorization

Release of Health-Related Information

AUTHORIZATION:

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years (My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to the insurance or reinsurance companies named below. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to The C.O.R.E. Group/C.O.R.E. Marketing (C.O.R.E.). 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.

Accordia	F&G Life	National Western Life	Royal Alliance
Avantax	Forethought	Nationwide	SBLI
Aegon	Genworth Financial	NBC Securities	Standard Life
AIG	Gerber Life	New York Life	Symetra
Allianz Life	Global Atlantic	North American	Transamerica
American General	Insource	Northwestern Mutual	United of Omaha
American National	Integrity Life	Ohio National	United Planners
Assurity	John Hancock	One America	William Penn
AXA Equitable	Hilltop Securities	Pacific Life	Zurich Kemper
Baker Birdwell	IDA Underwriting	Penn Mutual	1st Global
Banner Life	Layfayette Life	Principal Life	The Plus Group
Betcher Financial	Lincoln Financial	Protective Prudential	Western Int'l Securities
Brighthouse Financial	Mass Mutual	Reliance Standard	
Columbus Life	Minnesota Life		

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical file without restriction.

This protected health information is to be disclosed under this Authorization so that C.O.R.E. may 1) expedite underwriting my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; and 3) conduct other legally permissible activities that relate to any coverage I have or have applied for through C.O.R.E.

This authorization shall remain in force for 24 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to C.O.R.E. at the below address. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or to the extent that C.O.R.E. has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information.

THE C.O.R.E. GROUP

CENTERED ON RELATIONSHIP ENHANCEMENT

HIPAA Authorization

Release of Health-Related Information

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, C.O.R.E. may not be able to process my application. I understand that any authorized representative or I will receive a copy of this authorization upon request.

WAIVER & ACKNOWLEDGEMENT:

This waiver and acknowledgement has been signed on the date set forth below by the undersigned in favor of C.O.R.E., its successors, assignors and employees.

Applicant acknowledges, understands and agrees as follows:

- Applicant has filed an application with C.O.R.E. intending to secure life insurance from one or more insurance underwriters.
- In the course of applying for life insurance, C.O.R.E. 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.
- C.O.R.E. will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- C.O.R.E. cannot control the use, dissemination, publishing or interpretation of the information once that information is gathered by an Insurer or related company.
- 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 C.O.R.E.'s possession.
- Even though C.O.R.E. has in place security measures, C.O.R.E. believes appropriate to protect the information from unauthorized access and use, and even though C.O.R.E. will continue to upgrade those security measures as needed, C.O.R.E. can make no guarantee as to C.O.R.E.'s ability to protect the information from unauthorized access.

Signed at _____ , _____ this _____ day of _____ , _____.
city *state* *month* *year*

_____ _____
Name of Proposed Insured/Patient (Please print or type) *Date of Birth*

_____
Signature of Proposed Insured/Patient

_____
Witness

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THE C.O.R.E. GROUP

Quick Quote — Financial Justification

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

Give a complete listing of client's in-force life insurance:

COMPANY	AMOUNT	BENEFICIARY	REPLACEMENT?

Is this personal insurance? If yes, provide client's income (individual & household), and net worth?

_____

_____

If insurance is for business purposes, what is the percentage of proposed insured ownership? _____%

Amount of business insurance applied for/inforce on partners?

_____

_____

Explain details of the sale and any special circumstances of the case:

_____

_____

Include a 5 year replacement history on the case: _____

_____

_____

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Quick Quote — Hazardous Activities

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

Type of activity: _____

How often does the client participate in this activity? _____

How long has the client participated in this activity? _____

Skin/Scuba Diving (Check here if this is not applicable) ☐

Number of dives in last 12 months: _____ Number of dives in next 12 months: _____

Date of last dive: _____ Usual depth of the dives: _____

Maximum depth client has dived: _____ Date depth dived: _____

Usual time spent underwater: _____ Maximum time: _____

Where does client dive? (e.g. ocean, lake)? _____

List all certifications: _____

_____

Is diving the client's occupation? If YES, explain: _____

_____

Racing Cars, Boats, Motorcycles (Check here if this is not applicable) ☐

Type of vehicle and top speed: _____

If client races, what type of events: _____

Classification of vehicle and type of track: _____

Is race sanctioned by any association? If YES, explain: _____

Amateur or Professional? _____

Sky Diving (Check here if this is not applicable) ☐

Jump altitude and # of jumps in the last 12 months: _____

Number of expected jumps in the next 12 months: _____

Special certifications held by the client: _____

Amateur or Professional? _____

Please complete the "General Medical" form with every Quick Quote form.

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Quick Quote **Foreign Travel/Residence/Citizenship**

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

The client is a citizen of: _____

If not U.S. citizen, visa type or green card no. and date issued: _____

_____

How long has the client been in the US or Canada? _____

To what foreign country or countries does the client intend to travel? _____

_____

In what specific cities of these countries will the client be visiting? _____

_____

Will the client be traveling outside these metropolitan areas? _____

Purpose of trip: _____

Date(s) of visit & length of stay: _____

_____

_____

_____

Please provide details of foreign travel for the past 12 months (Location, Duration, and Purpose):

_____

_____

Does the client have family members who reside outside the US and Canada? If Yes, where?

_____

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Quick Quote — Aviation

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

Total flight hours logged: _____

Make of aircraft flown: _____

Type of certification: _____

Year certification issued: _____

Does client have Instrument Flight Rating (IFR)? _____

Hours flown in last 12 months: _____

Estimated hours during next 12 months: _____

Personal use (percentage): _____

Is the client a commercial pilot? _____

Business use (percentage): _____

If business use, please specify type of business (commercial or charter): _____

Any flying outside of the US? If yes, specify country: _____

_____

_____

Does insured fly military aircraft? If YES, what type of aircraft, hours flown per year, and total hours?

_____

Purpose and frequency of military travel: _____

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Quick Quote **Moral Hazards**

Agent: _____ Date: _____

Address: _____

_____ Email: _____

Phone: _____ Fax: _____

Client: _____ Date of Birth: _____

History (e.g. criminal record, lack of applicant candor, criminal associates, convictions, etc.):

_____

_____

Date(s) associated with incidence: _____

Date of occurrence(s): _____

Was client ever convicted? _____

If YES, has time been served or is case in appeal? Please explain: _____

_____

_____

Is client currently on parole? If YES, when will parole be lifted? _____

_____

Describe any lifestyle changes (e.g. stable employment, etc.): _____

_____

_____

_____

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