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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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: ____________________

____

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:

____

____

THE C.O.R.E. GROUP

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

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

7373 N. Scottsdale Road · Suite A-287 · Scottsdale, AZ 85253
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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: ______________________

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

THE C.O.R.E. GROUP

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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