Crump®
Life Insurance Services

TimeSaver™

Preliminary Inquiry — Not an application for life insurance.
This TimeSaver™ 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.

Crump Sales Manager ______________________ Phone ______________

PERSONAL HISTORY (this section must be completed)

Name	☐ Male ☐ Female	Social Security Number			
Address	City		State	Zip	
Date of Birth	Age	Height	Weight	Monthly Earned Income	Net Worth
Occupation					
Is the client a Foreign National? ☐ Yes ☐ No	If yes, list country of citizenship				
Has the client traveled outside the United States? ☐ Yes ☐ No	If yes, list the countries and dates visited				Please complete the Foreign Travel Questionnaire
Green Card? ☐ Yes ☐ No					
Type of Visa					

PRODUCER INFORMATION (this section must be completed)

Name	Social Security Number	Crump Producer Number	
Michael Quinn		14141929	
Address	City	State	Zip
Phone: 888-411-1329	Fax: 407-249-2720	Email Address: mike.quinn@lifeinsuranceblog.net	
Have you submitted this case previously? ☐ Yes ☒ No			

GOALS OF THE CASE (this section must be completed)

What is the ultimate goal of the case?	
What premium is needed to place the case?	
Are you in competition? ☐ Yes ☒ No	If in competition, with what companies?
Where has the case been shopped and list the outcome?	
Are there any carriers we shouldn't consider?	
Did you discuss this case with an Advanced Sales Associate? ☐ Yes ☒ No Did you discuss this case with an Underwriter? ☐ Yes ☒ No If yes, who? ______	Please check if applicable ☐ Business Planning ☐ Estate Planning ☐ Charitable Planning ☐ Other ______
Is your client interested in the following? ☐ Annuities ☐ Disability Insurance ☐ Long Term Care Insurance (please complete the Disability questionnaire on the website and attach to this TimeSaver™)	

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Proposed Insured ______________________ Social Security Number ______________________

REQUESTED COVERAGE (this section must be completed)

Minimum Consideration: **$500,000 face amount for permanent products** **$750,000 face amount for term products**	☐ Universal Life ☐ Survivorship (please have other proposed insured submit TimeSaver™ as well) ☐ Variable Life ☐ Whole Life ☐ Term, Level Period ______________
Face amount desired?	Will these premiums be financed? ☐ Yes ☐ No ☐ Possibly

If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? ______________

Provide details on pending and in-force coverage:

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?

Life Settlements: Indicate any activity in the past five years

TOBACCO/NICOTINE USAGE (this section must be completed)

Have you ever smoked cigarettes:

☐ Yes ☐ No If yes, date of last usage:

Have you used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐ Yes ☐ No

If yes, provide types and last date of use:

MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your primary care physician? When did you last consult him/her? Any ongoing medical treatment?			
What other physicians have you consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities have you ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

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FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below. ☐ Yes ☐ No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

DRUG AND ALCOHOL USAGE QUESTIONNAIRE ☐ check here if this section is not applicable

Do you currently drink alcohol? ☐ Yes ☐ No

Date of last consumption: ______________________

Do you ever drink substantially more than present? ☐ Yes ☐ No

If yes, when? ______________________

Have you ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details ______________________

Have you ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details ______________________

Type of drug(s) used ______________________ Date of last use ______________________

CORONARY ☐ check here if this section is not applicable

Date of diagnosis or first chest pain		Number of diseased vessels
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)		
Date of last stress EKG	Results	By whom?
Any pain since treatment/surgery?		

CANCER ☐ check here if this section is not applicable

Exact name and location of cancer	Stage and grade
Who would have the pathology report	Date/details of treatment/surgery

DIABETES ☐ check here if this section is not applicable

Date of diagnosis	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details
Do you regularly test your blood glucose? ☐ Yes ☐ No	Results	Frequency

Latest result of glycohemoglobin (A1C) test __________ mg% Date ______________

Have you been diagnosed with having protein and/or microalbumin in your urine? ☐ Yes ☐ No

Have you ever had:	Eye trouble ☐ Yes ☐ No	Heart trouble ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No
Have you ever had:	Kidney trouble ☐ Yes ☐ No	Neuritis/Neuralgia ☐ Yes ☐ No	Insulin reactions ☐ Yes ☐ No

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Are you a private pilot? ☐ Yes ☐ No If yes, provide details.	How many total hours have you flown as Pilot in Command? __________	How many hours do you fly per year? __________	Do you have an IFR (instrument flight rating) ☐ Yes ☐ No

Do you participate in the following activities? (check those that apply)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving
☐ Mountain Climbing ☐ Hang Gliding ☐ Auto/Motorcycle Racing ☐ Other ______________

DRIVING HISTORY ☐ check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

Please refer to our website or contact your Sales Manager for additional questionnaires and information.

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Proposed Insured ____________________ Social Security Number ____________________

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The undersigned insured(s) (hereafter referred to as "I", "me" or "my"), authorizes the use and disclosure of my personal health and medical information protected by state and federal law including the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

Description and Purpose of Disclosure: This authorization shall apply to any and all of my personal health and medical information, including medical records in their entirety which may contain mental health records (excluding psychotherapy notes, as defined by HIPAA) and restricted records, life expectancy reports, prescription drug records, HIV-related information, use of alcohol or controlled or prohibited substances, and employment records, whether or not personally or individually identifiable (collectively referred to as my "PHI"). This authorization and all uses and disclosures of my PHI made under this authorization are for the purposes of allowing Crump Life Insurance Services, Inc. and any affiliated companies (hereinafter collectively "Crump") and any Authorized Recipient (as defined below) to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

"Insurance Products and Services" means, for example, life insurance, disability insurance, life settlements (the selling of a policy in the secondary market), as well as premium financing and other similar types of products and services. Insurance Products and Services do not include long term care or other types of health insurance.

Classes of Persons Authorized to Disclose My PHI: I authorize any health care provider, including any doctor, hospital or medically-related facility, nurse, pharmacy, physician, practitioner, or practitioner practice group (each an "Authorized HCP"), and any insurance company, HMO/PPO or similar organization, employer or, except as may be limited by state law, any other organization, institution or person that has my PHI to disclose to Crump or any Authorized Recipient, any such records or information as provided under this authorization.

Classes of Persons Authorized to Receive My PHI: PHI received by Crump may be disclosed under this authorization to any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described (each an "Authorized Recipient").

Further Disclosure Authorization: I authorize each Authorized Recipient to further disclose my PHI as necessary to carry out the purposes under this authorization. I understand and acknowledge that PHI that is redisclosed by the Authorized Recipient may no longer be protected by law. I further acknowledge that some state and federal laws prohibit the further disclosure of information regarding the diagnosis, prognosis and treatment of drug or alcohol abuse, communicable diseases or infection including sexually-transmitted diseases or HIV without specific written consent. I hereby authorize Crump and each Authorized Recipient to further disclose the foregoing information to the extent such disclosure is necessary in order to carry out the purposes under this authorization.

Expiration of Authorization: This authorization shall remain valid for two (2) years after the date signed below.

Right to Revoke: I understand that I may revoke this authorization at any time by sending a written request for revocation to Crump or to any Authorized HCP at such address designated to me. Any revocation of this authorization shall not apply to the extent that any person has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

I understand that this authorization is a requirement for the underwriting, sale or settling of Insurance Products and Services and Crump may condition enrollment, eligibility, benefits, sale or settling of Insurance Products and Services on whether I sign this authorization. I also understand that since purchasing or settling Insurance Products and Services is not covered under HIPAA, this requirement does not prohibit this authorization from being used for multiple purposes, as described above. (Note to health care providers: life insurance, disability insurance and any other type of insurance to which this authorization would apply does not constitute a "health plan" under the HIPAA Privacy Rule. Accordingly, this authorization complies with the provisions of the HIPAA Privacy Rule governing authorizations (45 C.F.R. Sec. 164.508)).

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. I certify that I am executing and delivering this authorization freely and voluntarily as of the date written below. I further certify that I have received and retained a copy of this signed authorization for future reference.

____________________ ____________________
Signature of Insured/Proposed Insured Date

____________________ ____________________ ____________________
Signature of Authorized Representative Date Relationship/Authority to Represent

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Proposed Insured ______________________ Social Security Number ______________________

AUTHORIZATION FOR USE AND DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION (NPI)

I, the Policy Owner/Proposed Policy Owner, authorize Crump Life Insurance Services, Inc. or any affiliated company (hereinafter collectively "Crump") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient, as such terms are defined below. This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Crump and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

I, the Insured/Proposed Insured (if different than the Policy Owner/Proposed Policy Owner), authorize Crump Life Insurance Services, Inc. or any affiliated company (hereinafter collectively "Crump") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient (as such terms are defined below). This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Crump and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

"Nonpublic Personal Information" means information, including, without limitation, nonpublic personal, financial, health and medical information about the Policy Owner and Insured (if different than the Policy Owner) and the Policy Owner/Insured's identity as an owner/insured under a Life Insurance Policy that is obtained, whether from the Policy Owner/Insured, any of the Policy Owner's/Insured's agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

"Authorized Recipient" includes any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described.

"Insurance Products and Services" means, for example, life insurance, disability insurance, life settlements (the selling of a policy in the secondary market), as well as premium financing and other similar types of products and services. Insurance Products and Services do not include long term care or other types of health insurance.

The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each agree and consent that this authorization shall be effective from the date hereof until the earlier of (a) the date that is two (2) years after the date hereof, or (b) an earlier date as may be required by applicable law or regulation. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) have the right to revoke this authorization, at any time, by providing written notification to Crump.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each certify that he or she is executing and delivering this authorization freely and voluntarily as of the date written below. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) further certify that the authorization is written in plain language and acknowledge that each has received and retained a copy of this signed authorization for future reference.

______________________ ______________________ ______________
Signature of Insured/Proposed Insured Printed Name Date

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Proposed Insured ______________________ Social Security Number ______________________

AUTHORIZED RECIPIENTS

INSURANCE CARRIERS

Allianz Life Insurance Company of North America
Allstate Life Insurance Company of New York
American General Life
American National Insurance Company
American National Life Insurance Company of NY
Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of NY
Assurity Life Insurance Company
Aviva Life and Annuity Company
Aviva Life and Annuity Company of New York
AXA Equitable Life Insurance Company
Banner Life Insurance Company
Columbian Mutual Life Insurance Company
Companion Life Insurance Company
Fidelity Security Life Ins. Co.
First MetLife Investors Insurance Company
First Symetra National Life Insurance Company of New York
Genworth Life and Annuity Insurance Company
Genworth Life Insurance Company
Genworth Life Insurance Company of NY
Guardian Life Insurance Company
John Hancock Life Insurance Company (USA)
John Hancock Life Insurance Company of NY
Liberty Life Assurance
Life Insurance Company of the Southwest*
Lincoln Benefit Life Insurance Company
Lincoln National Life Insurance Company
Lincoln Life Insurance & Annuity Co. of NY
Lloyd's of London
MetLife Investors USA
Metropolitan Life Insurance Company
Minnesota Life Insurance Company*
Mutual of Omaha
National Life Insurance Company*
Nationwide Life Insurance Company
New York Life*
North American Co. for Life & Health
Pacific Life*
Penn Mutual Life Insurance Company
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life Insurance Company
Protective Life & Annuity Insurance Company
Prudential Life Insurance Company
ReliaStar Life Insurance Company (ING)
ReliaStar Life Insurance Company of NY (ING)
Securian Life Insurance Company
Security Life of Denver
Security Mutual Life Insurance Company of NY
State Life Insurance Company
Symetra Life Insurance Company
The Standard
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
United of Omaha Life Insurance Company
United States Life Insurance Company of NY
Western-Southern Life Assurance Company
William Penn Life Insurance Company of NY

Limitations apply; contact your Sales Manager for details.

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