Insurance Designers Informal Application

Insurance Designers of Kansas City
9401 Indian Creek Parkway, Suite 150, Overland Park, KS 66210
FAX:(913) 451-4947 Phone:(913) 451-3960 or (800) 255-0163

Insurance Designers of Kansas City is a full service brokerage organization committed to comprehensive insurance analysis for clients. Our on-site underwriting team and informal application process eliminates excess applications, examinations and excessive MIB reports. Learn how you are rated tentatively so you can start with the best potential formal application first!

Instructions

This application is for cases of $500,000 permanent coverage or $1,500,000 term insurance and greater amounts. Other amounts should utilize IDAKC's Quick Quote Application which can be downloaded at www.IDAKC.com in the underwriting section.

Please complete this form as thoroughly and accurately as possible, including physician's contact information, onset dates, prescription names and dosages. If additional space is needed, use page 4 or add a separate page. Complete, accurate information produces the most competitive carrier offers. Because of the significant expense involved in purchasing medical records, IDAKC's underwriter has final determination regarding pre-purchase of client's medical records. If submitting for Survivorship quotes, please complete a separate application for each proposed insured and submit together.

1. Broker/Advisor Information

Name _____ Firm/Agency_____

Phone_____ Fax_____ Email_____

2. Case Design Information

Check one; Single Life case Survivorship (complete 2 apps) 1st to Die (complete 2 apps)

Check one) Universal Life Variable Universal Life Whole Life (Term Period) Survivorship UL Other_____

Death Benefit Amount _____If no lapse, carry guarantees to age_____

Riders_____

Premium design (i.e. lump sum, 1035, limited pay)_____

Purpose of Coverage (i.e. estate plan, buy-sell, etc) _____

_____

3. Proposed Insured Information

Proposed Insured _____
Last Name First Name MI Daytime Phone

Social Security Number _____-_____-_____ Date of Birth _____

(Check one)
Male
Female

Drivers License No. _____ State of issue _____

Residence Address _____
Street City State Zip Code

Employer _____ Position _____

Duties_____ Year in this occupation_____

4. Foreign Travel/Citizenship

U.S. citizen? _____ How Long? _____ If no, country of citizenship _____ Dual Citizenship?_____

Have you traveled outside North America or Western Europe in the last 2 years or intend to do so in the next 2 years? _____ If yes, list dates traveled (or anticipated traveling dates), duration, country and purpose of trip on page 4.

5. Existing and Pending Insurance

A) Year issued Company Amount Purpose Keep or Replace?

B) Have you ever been rated substandard, declined or postponed when applying for Life, LTC or DI insurance?
Please include date and explain:

6. Lifestyle and Avocation Information

A) Have you flown or do you intend to fly other than as a fare paying passenger on a commercial airline in the last 2 years or the next 2 years? If yes, hours flown last year _____ Anticipated hours next 12 months _____
License type_____ Date of last flight_____ Aircraft type & purpose_____
B) Have you engaged in or plan to engage in scuba or skin diving?
If yes, Number of dives last year_____ Anticipated dives next 12 months_____ Maximum depth_____
Where do you dive? (i.e. rivers, open ocean, etc)_____
Purpose of diving (i.e. vacation, commercial, instructor)_____
C) Have you engaged or plan to engage in any type of motor vehicle or boat racing?
If yes, please provide complete details on license type, circuit, frequency

D) Have you engaged in or do you plan to engage in any mountain climbing, sky diving or any other hazardous sports or activities? If yes, please provide details immediately below or on page 4 if more space is needed.

E) Have you had any moving violations or been cited for driving while impaired?
Please provide details and date of occurrences

F) Have you declared bankruptcy, or been convicted of a felony offense in the last 10 years?
Please provide details

G) Do you use any tobacco or nicotine products presently?
How many years? Type & Amount per day Any plans to quit?

H) Have you ever used tobacco in any form? (check one) cigarettes cigar chew pipe snuff
Date last used Type & Amount per day

J) Do you consume drugs other than prescribed by a physician?
Please provide details

K) Do you consume alcohol? If yes, please specify type, quantity and frequency

L) Have you ever been treated for, or recommended to seek treatment for alcohol or drug abuse?
Please provide details

M) Do you exercise regularly? If yes, please specify type, duration and frequency per week

N) Do you manage your diet? Please explain

7. Medical Information

A) Height Weight Any change greater than 10 pounds in the last 2 years?
If yes, please explain

B) Medications Please list prescription and non– prescription medications used below be sure to include;
Date started Medication & Dosage Purpose Prescribing Doctor's name Results of use

8. Medical Care Providers Information

Please provide complete information for all doctors and health care facilities that have consulted with, or treated you in the last 10 years. If additional space is needed, please continue on page 4 or add a separate page.

Primary Care Physician's

Name_____ Phone # _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

Specialist or other Care Provider _____Phone # _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

Specialist or other Care Provider _____Phone #__ _____

Address (street)_____(city)_____(State)_____(Zip)_____
Date and purpose & results of last visit

9. Medical Questions

Please provide details (diagnosis, onset date, duration of condition, treatments and current status) to any "Yes" answers on the next page

Within the last 10 years, have you had symptoms of, or been told by a physician that you have had or have;

A) Chest pain, shortness of breath, heart murmur, high blood pressure, stroke (TIA), irregular heartbeat or any other disease or disorder of the heart or arteries?
B) Diabetes, elevated blood sugar or glucose intolerance or disease of any glands?
C) Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?
D) Arthritis, gout or any bone, joint, muscle or skin disorder?
E) Asthma, bronchitis, pneumonia, emphysema or any lung disorder?
F) Cirrhosis, hepatitis, ulcer, colitis, diverticulitis, ileitis, or other disease of the liver, gall bladder, pancreas, stomach or intestines?
G) Prostate or testicular disease, disease of the uterus, ovaries or breasts?
H) Anemia, leukemia, clotting disorders, platelet disorders, infections, or sources of blood loss?
I) Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?
J) Cancer or tumors of any kind, malignant or benign?
K) Any other health impairment or medically treated condition not yet mentioned?
L) Been advised to seek treatment for any impairment or condition that has not been treated?

General and Medical Question Responses/Details

Please provide the question number and details as appropriate. For Medical questions, Please provide as much detail as possible regarding diagnosis, onset date, duration of condition, treatments, current status and caregiver/ provider with contact information (if different from those listed in section 8.)

Question #	Dates	Details

INSURANCE DESIGNERS of Kansas City

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Act and Privacy Rules

Patient Name _____

Date of Birth _____Social Security No._____
This authorization is for Release of Health-Related Information to the following:

Name_____

Address_____City_____State_____Zip_____

My Providers are any health plan physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefits manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf. This includes psychotherapy care. My Protected Health Information is my entire medical record and other health information. It includes information such as: the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness; the use of alcohol, drugs, and tobacco; and psychotherapy notes.

I authorize my Providers to disclose my Protected Health Information to the above name company or person(s); their agents, employees and representatives.

By signing below: 1) I acknowledge that any agreements I make that restrict my Protected Health Information do not apply to this authorization; and 2) I instruct My Providers to release and disclose my Protected Health Information without restriction.

This Protected Health Information is to be disclosed under this Authorization so that the above named may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or provide coverage and benefits; 4)administer coverage; and 5) conduct other activities that are allowed or required by law and relate to any coverage I have or have applied for with the above named. This authorization shall remain in force for 30 months following the date below. A copy of this Authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time by doing so in writing and presenting the written revocation to the above named. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to an insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. 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 Protected health Information, the above named may not be able to assist me in processing my application.
I acknowledge that I have received a copy of this Authorization.

Patient or personal representative signature_____ Date_____

Authorized Insurance Carriers

4Pluris LLC., 21st Services, Portamedic & Equifax Services, AIG Life, All-American Life Insurance Companies, Allianz Life, American General Life Insurance Company, American National Life Insurance Company, Asher Group, LLC., Assurity Life, AVS Underwriting, LLC., Accordia Life/Global Atlantic Financial Group, Equitable, Life Insurance Settlements, Inc., Banner Life/Legal & General, Canada Life, Columbus Life, Coventry First, Pacific Life, Genworth Financial Companies, Gerber Life, Hartford, ING/VOYA Companies, John Han-cock, John Hancock USA, Independent Funding Group, Insurance Designers, Lifetrust LLC, Lincoln National Life, Maple Life Financial, Inc., Mass Mutual, Metropolitan Life Companies, Minnesota Life, Mutual of Omaha/United of Omaha, National Life Group/Life of the Southwest, Nationwide Financial, New York Life, North American Company for Life and Health Insurance, OneAmerica/Satte Life, Oxford Life, Pacific Mutual, Peachtree, Phoenix Life Insurance Company, Principal National Life/Principal Life Insurance, Protective Life, Prudential Life, Secu-rity Life of Denver Insurance Company, Symetra Life, Transamerica Life Companies/Western Reserve Life, Travelers, Trinity Financial Ser-vices LLC, Twenty6 West Financial LLC, U.S.G. Life Insurance Company, Welcome Funds, Zurich Life.

Notice of Information Practices Provided by Insurance Designers
GIVE THIS PAGE TO THE PROPOSED INSURED

Collection of Information

To underwrite your insurance, information my be collected concerning your age, occupation, physical condition, health history, avocations, or other information necessary to determine appropriate premium rates. The companies listed below may obtain information from medical practitioners or institutions which have provided care to you or your family and from your employers, business associates, friends, neighbors, other insurance companies, the Medical Information Bureau, (MIB), or from an Investigative Consumer Report prepared by an independent reporting firm. If they request such an Investigative Consumer Report, you have the right to ask to be interviewed and, upon written request, to receive the contents of the report from the reporting company. If the report affects your application as requested, they will so notify you and provide you with the name and address of the reporting firm. Further information on the nature and scope of the reports will be provided upon written request to the companies listed below. You may request their address by writing to Insurance Designers, 9401 Indian Creek Parkway, Suite 150, Overland Park, KS 66210

Medical Information Bureau

The companies listed below will treat information regarding you as confidential. They may make a brief report to the Medical Information Buereau, a non-profit membership organization of the life insurance companies. It operates an information system exchange for its members. The Bureau, upon written request, will give information it may have in its file to a member company: 1) if you apply to a member company for life or health insurance; or 2) if you make a claim for medical benefits. If you send a request to the Bureaus, it will arrange to disclose the information it may have in your file. Medical information will be disclosed only to your attending physician. If you question the accuracy of information in the Bureau's file, you may seek correction. The address of the Bureau's information office is P.O. Box 105 Essex Station, Boston, MA 02112. The phone number is (617) 426-3660.

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Supplemental Information for Life Settlement Feasibility Quote

Life settlement markets vary greatly depending on many factors, including client life expectancy, policy viability and the overall settlement marketplace. Complete the client and health information in pages 1 through 3 and provide the following policy information. Our in-house underwriters can consult on the feasibility of bringing your policy to the life settlement marketplace for competitive bidding.

1. Death Benefit Amount _____
2. Policy Type (i.e. UL, VUL, WL Term) _____
3. Carrier _____
4. Policy Date _____
5. Policy (gross cash) value _____
6. Surrender value _____
7. Outstanding loan amount _____
8. Scheduled annual premium _____
9. Has an in force ledger been requested? _____ If yes, what is the minimum annual premium necessary to carry policy to maturity?_____
10. Any other comments may be entered below. Thank you