TimeSaver™

A proven solution for your impaired risk cases

The TimeSaver™ is the most widely accepted preliminary inquiry in the industry. This powerful tool helps identify the right solution for your impaired risk clients.

underwriting

Limited to permanent and term cases with face amounts of $1 million or greater.

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The TimeSaver™

underwriting

The TimeSaver™ (our informal inquiry) helps to identify potential solutions for your impaired risk clients by expediting the research of multiple carriers and determining which are more likely underwrite your clients to obtain a competitive offer.

GOALS

The goals section of the TimeSaver asks for imperative information that will help your Underwriter and sales team narrow down which carriers will be the best candidates for your clients. By knowing the premium tolerance, product information, and if the case was previously sent to carriers, we can focus on how to specifically negotiate with each carrier – helping to get you the offer needed to complete a sale.

PERSONAL HISTORY

The TimeSaver allows you to collect details that would not necessarily be addressed in medical records. Hazardous avocations, foreign travel, and driving history are important factors often overlooked in the informal underwriting process. Since these factors have a direct impact on the underwriting rate class, providing this information at the start of the process allows your Underwriter to address these issues head on, eliminating surprises and delays later in the underwriting process.

The TimeSaver is limited to permanent and term cases with face amounts of $1 million or greater.

MEDICAL INFORMATION

Our job is to tell your client's story to the carrier. The TimeSaver can be instrumental in collecting the details of your client's medical history that helps our underwriters tell the story. Contact information for doctors, dates of treatments, medications, and build are pertinent aspects of any case. By you fully completing all medical sections of the TimeSaver – especially providing information on the more complex medical issues such as cancer, diabetes, or cardiac disease – valuable insight is gained to help determine what medical records should be ordered upfront, reducing the overall time it takes to complete the file.

While an offer is never guaranteed until the formal process is finalized, with a fully completed TimeSaver, the most accurate facts can present each case in a more favorable light.

CREDITS

The purpose of this section is to help your Underwriter best position your file with our carriers by highlighting any additional positive aspects of your medical or social history. Several of our carriers have crediting programs that can improve a proposed insured's underwriting assessment by one or more classes.

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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.

Account 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	Producer Number	
Address	City	State	Zip
Phone	Fax	Email Address	
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 ☐ Traditional Long Term Care Insurance ☐ LTC Hybrid Product (please complete the Disability questionnaire on the website and attach to this TimeSaver™)	

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Proposed Insured _____

REQUESTED COVERAGE (this section must be completed)

Minimum Consideration: $1 million face amount for permanent and term products	☐ Universal Life ☐ Survivorship (please have other proposed insured submit TimeSaver™ as well) ☐ Variable Life ☐ Whole Life ☐ LTC Rider ☐ 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? _____	
Was a recommendation made to the proposed insured to: Use distributions from an IRA or qualified plan to purchase this insurance coverage? ☐ Yes ☐ No Hold this insurance coverage in a qualified plan? ☐ Yes ☐ No	

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)

Has your client ever smoked cigarettes:

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

Has your client 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:

MARIJUANA USAGE (this section must be completed)

Does your client use marijuana ☐ Yes ☐ No If yes, complete the following:

Purpose ☐ Recreational/Social ☐ Medicinal Frequency _____ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Inhaled Date Last Used _____

MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your client's primary care physician? When did your client last consult him/her? Any ongoing medical treatment?			
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client 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

Does your client currently drink alcohol? ☐ Yes ☐ No

Type(s) of Alcohol _____

Date of last consumption _____

How much per week _____

Does your client ever drink substantially more than present? ☐ Yes ☐ No

If yes, when? _____

Has your client ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details _____

Has your client 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
Does your client regularly test his/her blood glucose? ☐ Yes ☐ No	Results	Frequency

Latest result of glycohemoglobin (A1C) test _____ mg% Date _____

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

Have your client ever had: Eye trouble ☐ Yes ☐ No Heart trouble ☐ Yes ☐ No High blood pressure ☐ Yes ☐ No

Have your client ever had: Kidney trouble ☐ Yes ☐ No Neuritis/Neuralgia ☐ Yes ☐ No Insulin reactions ☐ Yes ☐ No

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Is your client a private pilot? ☐ Yes ☐ No If yes, provide details.	How many total hours has your client flown as Pilot in Command? _____	How many hours does your client fly per year? _____	Does your client have an IFR (instrument flight rating) ☐ Yes ☐ No

Does your client 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 Account Manager for additional questionnaires and information.

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Proposed Insured _____

UNDERWRITING CREDITS

Completing the information below can help us secure the best offer for your client as many carriers can use various crediting options to improve offers.

	Date of Testing	Doctor Contact Information
Complete physical exam by a physician within the past year		
Executive physical (Mayo, Cooper Clinic, Cleveland Clinic) within the past year		

Preventative wellness studies within the past two years with normal results	Date of Testing	Doctor Contact Information
☐ Digital rectal exam		
☐ PSA testing		
☐ Physician skin exam		
☐ Physician testicular exam		
☐ Colonoscopy		
☐ Occult blood in stool testing (stool cards)		
☐ Bone density test		
☐ Mammogram		
☐ Pap smear		
☐ Physician breast exam		

Exercise (list type of exercise, how many times per week and length of each session)

_____

Cardiac testing within the past two years with normal results	Date of Testing	Doctor Contact Information
☐ Resting EKG		
☐ Treadmill stress test		
☐ Nuclear stress test		
☐ Echocardiogram		
☐ Catheterization or angiogram		
☐ Coronary Calcium Testing (EBCT) with a zero score		

Other testing within the past two years with normal results	Date of Testing	Doctor Contact Information
☐ Chest CT		
☐ Abdominal CT		
☐ Normal CBC (Complete Blood Count)		
☐ Normal Pulmonary Function Testing/Spirometry		

Older Age (70+)

- ☐ Driving (distance traveled per week in miles)_____
- ☐ Social clubs/groups/volunteer work_____
- ☐ Hobbies_____
- ☐ Travel in the past year_____
- ☐ Does the client handle their own financial affairs/investments?_____
- ☐ Does the client work full time, part time, or in consulting?_____

Please refer to our website or contact your Account 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 CBS Brokerage and any affiliated companies (hereinafter collectively "CBS") and any Authorized Recipient (as defined below) to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or (2) market Insurance Products and Services to me.

"Insurance Products and Services" means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also 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 CBS 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 CBS 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 CBS 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 CBS 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.

This authorization complies with the provisions of the HIPAA Privacy Rule governing authorizations (45 C.F.R. Sec. 164.508). I understand that this authorization is a requirement for the underwriting, sale or settling of Insurance Products and Services and CBS may condition enrollment, eligibility, benefits, sale or settling of Insurance Products and Services on whether I sign this authorization.

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 CBS Brokerage or any affiliated company (hereinafter collectively "CBS") 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 CBS and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or; (2) market Insurance Products and Services to me.

I, the Insured/Proposed Insured (if different than the Policy Owner/Proposed Policy Owner), authorize CBS Brokerage or any affiliated company (hereinafter collectively "CBS") 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 CBS 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, as well as premium financing and other similar types of products and services. Insurance Products and Services also 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 CBS.

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 _____

AUTHORIZED RECIPIENTS

INSURANCE CARRIERS

Allianz Life Insurance Company of North America
American General Life Insurance Company
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
Assurity Life Insurance Company of New York
AXA Equitable Life Insurance Company
Banner Life Insurance Company
Brighthouse Life Insurance Company
Brighthouse Life Insurance Company of New York
Columbian Life Insurance Company
Columbian Mutual Life Insurance Company
Companion Life Insurance Company
Fidelity Security Life Insurance Company
Fidelity Security Life Insurance Company of New York
First Symetra National Life Insurance Company of New York
Foresters
Forethought Life Insurance Company
Gerber Life Insurance Company
Global Atlantic Financial Group
Guardian Life Insurance Company
Illinois Mutual Life Insurance Company
John Hancock Life Insurance Company (USA)
John Hancock Life Insurance Company of NY
Life Insurance Company of the Southwest*
LifeSecure Insurance Company
Lincoln Life Insurance & Annuity Co. of NY
Lincoln National Life Insurance Company
Lloyd's of London
Mass Mutual*
Minnesota Life Insurance Company
Mutual of Omaha
National Guardian Life Insurance Company
National Life Insurance Company*
Nationwide Life Insurance Company
New York Life*
North American Co. for Life & Health
Pacific Life & Annuity Company*
Pacific Life*
Pan American Life*
Penn Insurance & Annuity Company
Penn Mutual Life Insurance Company
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life & Annuity Insurance Company
Protective Life Insurance Company
Prudential Life Insurance Company
ReliaStar Life Insurance Company of NY
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
The Standard Life Insurance Company of New York
The United States Life Insurance Company in the City of New York
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
United of Omaha Life Insurance Company
Voya Financial
Western-Southern Life Assurance Company
William Penn Life Insurance Company of NY

**Limitations apply; contact your Regional Director for details.*

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