

Quick-Solve

We Solve Impaired Risk Cases

Quick-Solve is the most widely accepted preliminary inquiry in the industry. This powerful tool helps identify the right solution for impaired risk clients.

Quick-Solve™

Preliminary Inquiry— Not an application for life insurance.

This Quick-Solve™ 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.

Personal History

Name _____ Male Female Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Height _____ Weight _____

Monthly Earned Income _____ Occupation _____

Tobacco/Nicotine Usage

1. Have you ever smoked cigarettes: Y / N if yes, date of last usage: _____ - _____ - _____

2. Have you used other tobacco or nicotine containing products: Y / N (examples: cigars, pipe, snuff, nicotine gum or patch)

If yes, provide types and last date of use:

Agent Information

Name _____ Soc. Sec. # _____ Agent ID _____

Address _____ City _____ State _____ Zip _____

Office Phone No. _____ Fax No. _____

Email Address _____

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Plan Of Insurance Requested

Due to the time put into pre-underwriting a minimum consideration of \$250,000 face amount and/or minimum annual premium of \$2,500 is required for impaired risk Quick-solve Applications.

Universal Life
 Variable Life
 Whole Life
 Term, Level Period _____
 Survivorship*
 Disability Income, Monthly Benefit Amount _____
 Face amount desired: _____ Premium amount desired: _____
 Annually Monthly

Will these premiums be Financed? Y / N If yes, complete the Addendum to the Quick-Solve™ Preliminary Inquiry for Premium Financing Programs HIPAA Authorization

If you are replacing coverage, will there be any 1035 money with this replacement? Y / N If yes, what amount will be carried over? \$ _____

What is the purpose of the insurance? _____

*Survivorship Needs -Please have other proposed insured submit Quick-Solve as well.

Provide details on pending and in-force coverage:

Company Policy	Policy/Application Date	Amount	Class /Rating issued	Current Premium	Will You be Replacing?
					Y/N
					Y/N
					Y/N
					Y/N

1. Who is your primary care physician? Doctor's name, address, and phone number
When did you last consult him/her? Why?

Date _____ Illness _____

2. What other physicians have you consulted during the past five years? Why?
(Do not include insurance examinations.)

Dr Name _____ Address _____
Date _____ Reason _____

Dr Name _____ Address _____
Date _____ Reason _____

Dr Name _____ Address _____
Date _____ Reason _____

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3. In what hospitals, clinics, or other health facilities have you ever been treated?

4. Please list all current medications.

Family History

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Yes No

If yes, please provide the following details:

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

Drug and Alcohol Use

Do you currently drink alcohol? Yes No

Did you ever drink substantially more than present? Yes No
Date of last consumption: _____ If yes, when _____

Note amount below.

Note amount below.

Type	Amount Per Week	Type	Amount Per week
Beer		Beer	
Wine		Wine	
Liquor		Liquor	

Have you ever used illegal drugs or sought treatment because of drug use? Y N

If yes, provide details:

Types of drug(s) used:

Date of last use:

Doctor/Facility name and address:

Proposed Insured: _____ Soc. Sec. #: _____

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Coronary Check here if this section not applicable

1. Date of diagnosis or first chest pain: ____ - ____ - ____

2. Number of diseased vessels:

3. Dates/details of treatment/surgery (examples: Angioplasty, Bypass)

4. Date of last stress EKG: ____ - ____ - ____

Results:

By whom?

5. Any pain since treatment/surgery?

Cancer Check here if this section not applicable

1. Exact name and location of cancer:

2. Stage and grade:

3. Who would have the pathology report?

4. Dates/details of treatment/surgery:

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Diabetes Check here if this section not applicable

1. Date of diagnosis: _____ - _____ - _____
2. Treatment: Diet Only Oral Medication Insulin
Details: _____

3. Do you regularly test your blood glucose? Yes No
Results: _____ Frequency: _____
4. Latest result of glycohemoglobin (A1C) test: _____ mg%
Date: _____ - _____ - _____
5. Have you been diagnosed with having protein and/or microalbumin in your urine? Yes No
6. Have you EVER had?
A. any eye trouble? Yes No
B. heart trouble? Yes No
C. high blood pressure? Yes No
d. kidney trouble? Yes No
e. neuritis/neuralgia? Yes No
f. insulin reactions? Yes No

Hazardous Activities Check here if this section not applicable

Are you a private pilot? Yes No
If yes, provide details below.
How many total hours have you .own as Pilot in Command?

How many hours do you .y per year?

Do you have an IFR (instrument Flight rating)? Yes No

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

Scuba Diving	Mountain Climbing
Bungee Jumping	Hang Gliding
Ultra light Flying	Auto/Motorcycle Racing
Sky Diving	Other _____

Proposed Insured: _____ Soc. Sec#. _____

.Date: _____

Print Name: _____ Soc. Sec. # _____

Signature _____

AUTHORIZATION

This Authorization is HIPAA compliant

Proposed Insured: _____

Date of Birth: _____ Social Security: _____

Purpose:

The purpose of this Authorization is to permit Trinity 1 Agents "Agencies" to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the Companies") listed on the reverse of this document information that may be released to and disclosed by Trinity 1 Agents "Agencies" and the Companies listed on the reverse of this document pursuant to this Authorization shall include any and all information, to the extent permitted by applicable law.

Information to be Released:

The information to be released pursuant to this Authorization includes any personal health information records or data concerning my past, present or future mental, physical or behavioral health or condition ("Information"), to the extent permitted by law.

Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that this Information may include results from blood, saliva, urine and other tests.

I further understand that this information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted disease; HIV infection, including medical test results.

Authorization:

I authorize any physician or other medical practitioner, any hospital, clinic, or other health related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such information to Trinity 1 Agents "Agencies", and its authorized representatives.

I specifically authorize the Companies listed on the reverse of this document to receive information from and to release information to Trinity 1 Agents "Agencies". I also specifically authorize Trinity 1 Agents "Agencies" and the Companies listed on the reverse of this document to release information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau Inc. (MIB) to release information directly to any Company listed on the reverse of this document, upon such insurer's request, provided the insurer is a member of MIB.*

I understand that information disclosed to Trinity 1 Agents "Agencies" may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to Trinity 1 Agents "Agencies", it may no longer be subject to those laws and regulations.

I also authorize my Agent, named below, to receive Information and I authorize Trinity 1 Agents "Agencies" to disclose such information to my Agent, to assist in the purpose of this Authorization the extent permitted by law.

A photocopy of this Authorization shall be as valid as the original.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to Trinity 1 Agents "Agencies" at 36 South Main Street, Manasquan, New Jersey 08736. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

Proposed Insured's Signature (or that of Authorized Representative) Date

Print Name of Proposed Insured

If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child.

Print Name of Agent

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB.

All pages of the Quicksolve must be completed. Inquiry cannot be considered unless authorization is signed and initialed by Propose insured.

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB, as a part of our underwriting process we or one of the insurance companies listed below may request an investigative consumer information report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such as report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or others with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is normally conducted, but you are entitled to make a specific request.

We keep such information reports confidential and use them only to evaluate and underwrite your application.

You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

We treat what we know about you confidentially. Our employees are told to take care in handling you information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

We may disclose personal; information about you without prior authorization under certain circumstances. For example, we may disclose information about you to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. We may give information to accounting firms performing audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which you have applied for coverage or benefits. Information may be furnished your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law.

We may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which you may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured lives.

No medical record information or personal information relating to your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

You Can View and Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside Trinity 1 Agents "Agencies".

If you want to know more about our privacy policy, please contact us at Trinity 1 Agents "Agencies", Compliance Department.

Proposed Insured Initials: _____ Date: _____

Print Name: _____ Social Security: _____

Acacia Mutual	Companion Life of NY	Hartford Life Insurance	New York Life	Security Mutual Life
American General Life	Continental Assurance Company	Illinois Mutual	North American Life & Health	Southland Life
American General Life of NY	Coventry First	Indianapolis Life Insurance Company	North American Life & Health of NY	Standard
AIG Life	EFinancial	Jefferson Pilot Life Insurance	Old Line Life	State Life
AIG of NY	Empire General Life EMSI	John Hancock Life Insurance Company	Old Republic Life	Sun Life Financial
Allianz Life Insurance Company	Equitable Life of Iowa	Keyport Life Insurance Company	Phoenix	Travelers Insurance
American Mayflower	Fidelity Security F&G	Lincoln Benefit Life	Physicians Mutual Life	UNUM Insurance
American National Insurance Company	First Colony	Lincoln Life	Protective Life	United of Omaha
American Life Insurance Company of NY	First Penn-Pacific	Lincoln Life of NY	Prudential Life Insurance Company	Unum Provident Corporation
Bankers Life of NY	First UNUM	Lloyd's of London	Principal Life Insurance Company	US Financial
Banner Life	GE Capital Assurance	Massachusetts Mutual Life	Provident Life & Accident	US Life Insurance Co. In the City of NY
BISYS Insurance Services	GE Capital Assurance of NY	Manulife USA	Provident Mutual	Valley Forge Life
Boston Mutual	GE Financial Assurance	Manulife USA of NY	Prudential Insurance	West Coast Life
Business Mens Assurance Co. of America	GE Life & Annuity/LOV	Metropolitan Life Insurance Company	ReliaStar Life Insurance	William Penn
Canada Life Assurance	General American Life Insurance Co.	MDNY	ReliaStar Life Insurance of NY	Zurich Life
Canada Life of NY	Gerber Life Insurance Company	Mutual of Omaha	Security Connecticut	Zurich Life Insurance Company of NY
CNA	Guarantee Trust Life	Nationwide	Security Life of Denver	

All pages of the QuickSolve must be completed. Inquiry cannot be considered unless authorization is signed and initialed by Proposed insured.