DISABILITY INCOME EVALUATION

for the protection of your family

Confidential Information Gathering Kit

FIRST ELEMENT
INSURANCE PLANNERS

Please Return Completed Form To:
RMTeam@firstelementinsurance.com
Questions? Call (866) 351-3745

COMPLETION OF EACH SECTION IN ITS ENTIRETY IS REQUIRED TO COMMENCE A DISABILITY INCOME EVALUATION

Date	Advisor's Name	Advisor's Phone Number

Client Profile

Full Name		Date of Birth
State of Residence	Sex	Marital Status

Occupation

Occupation	What are your occupational duties?
Are you a federal, state or city employee? ☐ Yes ☐ No	Length of time at your current employer: _____
Are you self-employed? ☐ Yes ☐ No	What percentage of the business do you own? _____ How long have you owned the business? _____

Financial

Estimated annual net income (after expenses if self-employeed)	$
Estimated annual bonus (if applicable)	$
Do you have annual unearned income (e.g. dividend, interest) that exceeds 10% of your earned income or does your net worth exceed $3,000,000	☐ Yes ☐ No

Other Insurance

Do you have any other group or individual disability coverage?	☐ Group ☐ Individual ☐ None
Will you be replacing your current coverage?	☐ Yes ☐ No ☐ N/A

Key Questions

How much of your income would your family need if you became disabled?	%
How much income would your family need if your spouse became disabled?	%
If you were to become disabled, could you meet household expenses for 90 days without liquidating assets?	☐ Yes ☐ No

Level of Concerns

	None	Low	Medium	High
Your ability to maintain your position, and thus your income, in the event of a partial disability	☐	☐	☐	☐
The concern of your benefit keeping pace with rising inflation costs	☐	☐	☐	☐
Your ability to pay premium if an insurance company were to increase your rates	☐	☐	☐	☐
Importance of receiving a benefit if you cannot perform your occupation, but can perform another occupation	☐	☐	☐	☐
Importance of being able to increase your insurance benefit based upon substantial salary increases	☐	☐	☐	☐
The concern over social security impeding a private insurance benefit	☐	☐	☐	☐
The importance of receiving a portion of your premium back at the end of the policy period	☐	☐	☐	☐
Importance of receiving a greater benefit in the event of a catastrophic disability (inability to perform multiple activities of daily living)	☐	☐	☐	☐

Lifestyle Questions

1. Within the past 12 months, have you used tobacco or nicotine in any form? (including gum, patch, and electronic cigarettes)	☐ Yes ☐ No	
Product(s):	Frequency (daily, 1/month, etc.):	Date of last use:
2. Within the past five years, have you had a driver's license revoked or suspended?	☐ Yes ☐ No	
3. Have you ever been charged with, or convicted of, or currently awaiting trial for a felony violation of any criminal law?	☐ Yes ☐ No	
4. Within the next two years, do you have any intention of residing outside of the U.S. or traveling outside of the U.S. or Canada?	☐ Yes ☐ No	
5. Within the past two years, have you engaged in, or in the next twelve months do you intend to engage in, any hazardous activities *(such as scuba diving, motorized racing, skydiving, hang-gliding, mountain climbing, aviation)*?	☐ Yes ☐ No	

Health Questions

1. Have you ever received or applied for disability insurance benefits due to sickness or injury?	☐ Yes ☐ No
2. Have you ever applied for insurance or reinstatement of a lapsed policy which has been declined, postponed, rated, modified, or had any such insurance canceled or a renewal premium refused? **Answer this question "No" if any of these actions were taken because you have been tested for HIV, but have not developed symptoms of the disease AIDS or ARC.**	☐ Yes ☐ No
3. Within the past six months, have you missed work due to, or been treated for, sickness or injury?	☐ Yes ☐ No
4. Have you ever been diagnosed with or medically treated for:	
heart attack, angina, coronary artery disease, stroke, mini-stroke, high blood pressure *(include last reading in details below)*, or any other type of heart or circulatory system disease?	☐ Yes ☐ No
any form of cancer *(including leukemia, lymphoma, or cancer of the bone marrow)*?	☐ Yes ☐ No
any chronic or progressive disease or disorder of the: kidneys, liver, lung or respiratory system, pancreas, muscles or connective tissue, joints, eyes, ears, bone marrow, digestive system, brain, nervous system or immune system *(excluding HIV)*; or have you been diagnosed with sleep apnea or diabetes *(non-pregnancy related)*?	☐ Yes ☐ No
seizures, multiple sclerosis, anxiety, depression, Epstein-Barr virus, chronic fatigue, or fibromyalgia?	☐ Yes ☐ No
spinal, neck or back disorder or injury, including sprains, or disc disorder?	☐ Yes ☐ No
5. Have you ever been diagnosed by a licensed medical professional or tested positive for Acquired Immune Deficiency Syndrome (AIDS)? **Answer this question "No" if you have been tested for HIV, but have not developed symptoms of the disease AIDS or ARC.**	☐ Yes ☐ No
6. Have you taken any prescription medications in the past 12 months? *(list all medications and reasons below)*	☐ Yes ☐ No
7. Within the past 10 years, have you used marijuana, cocaine, barbiturates, tranquilizers, heroin, LSD, amphetamines, morphine, narcotics, or any other drug except as legally prescribed by a physician, or sought or received treatment for the use of alcohol?	☐ Yes ☐ No
8. Within the past five years, other than noted above, have you been a patient in a hospital or other medical facility?	☐ Yes ☐ No
9. Height: _____ Weight: _____	
10. Have you lost or gained 20 or more pounds in the past 12 months?	☐ Yes ☐ No

Please provide any additional medical or lifestyle information that should be considered during the quoting process. Attach additional sheet, if needed.

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize BUI (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. 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.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to BUI, 11433 Olde Cabin Road, Third Floor, St. Louis, Missouri 63141, and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured/Personal Representative Signature	Proposed Insured Name	Description of Personal Representative's Authority/Relationship to Insured	
Proposed Insured Social Security #	Proposed Insured Date of Birth	Signed and Dated On	At (City, State, Zip Code)

Agent/Witness Signature: _____ **Print Agent/Witness Name:** _____

Accordia Life, AIG, American General Life Insurance Company, American National Insurance Companies, American United Life Ins. Co., Athene, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Financial, Companion Life Insurance Company, Genworth Financial Family of Companies, General Re Life Corp, Global Atlantic, John Hancock, Lincoln National Life, Mutual of Omaha Insurance Companies, Minnesota Life, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, OneAmerica, North American Co. for Life and Health, Pioneer Mutual Life Ins. Co., Principal Life Insurance Co., Principal National Life Insurance Co., Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Savings Bank Life Ins. Co., Security Life of Denver Insurance Company, Security Mutual Insurance Company, Symetra, The Cincinnati Life Insurance Company, The State Life Ins. Co., TIAA-CREF Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, VOYA Financial, Inc., William Penn Life Insurance Company of New York, Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York.