KEY PERSON EVALUATION

for the continued success of your business

Confidential Information Gathering Kit

FIRST ELEMENT
INSURANCE PLANNERS

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

THIS SECTION MUST BE COMPLETED BY A REPRESENTATIVE OF THE COMPANY/ORGANIZATION

DATE	ADVISOR'S NAME	ADVISOR'S PHONE NUMBER

COMPANY/ORGANIZATION INFORMATION

NAME OF COMPANY/ORGANIZATION	STATE OF DOMICILE	NUMBER OF EMPLOYEES

COMPANY/ORGANIZATION TAX STATUS (check one)

☐ **S - CORPORATION** ☐ **C - CORPORATION** ☐ **PARTNERSHIP** ☐ **SOLE PROPRIETORSHIP** ☐ **TAX-EXEMPT NONPROFIT**

KEY PERSON EVALUATION

Part 1: Key Person Information

Name of Key Person	Key Person's Job Title

Description of Key Person's Job Responsibilities

What makes the person key? *check all that apply*

☐ Special contracts/connections	☐ Sales ability	☐ Financial expertise
☐ Management ability	☐ Product design/innovation	☐ Leadership skills
☐ Computer/technical skills	☐ Ability to get things done	☐ Other: _____

Part 2: Key Person's Total Annual Compensation	
Salary, bonuses, and any other form of compensation including company car allowance, club membership, etc.	$
Part 3: Lost Profits	
Revenues attributable to key person	$
Profit margin percent on revenues	%
Number of years to replace	#
Part 4: Additional Expenses	
Replacement's total compensation and benefits	$
Recruiting, advertising and placement costs	$
Training expenses	$
Increased interest cost on business loans	$
Other costs (please specify)	$
Part 5: Additional Information	
Number of years the key person is anticipated to be employed by the company/organization	#
Estimated fair market value of the company	$
Key person's equity/ownership in the company	%

PLEASE ATTACH ADDITIONAL PAGES IF ADDITIONAL EXPLANATION IS NECESSARY

THIS SECTION MUST BE COMPLETED BY THE KEY PERSON

KEY PERSON INFORMATION				
NAME OF KEY PERSON	NAME OF COMPANY/ORGANIZATION			
STATE OF RESIDENCE	DATE OF BIRTH	HEIGHT	WEIGHT	SEX

KEY PERSON'S HEALTH INFORMATION

1. Have you ever applied for life insurance in the past? If "Yes", for most recent application please provide company name, rate class, face amount, and date. ☐ **Yes** ☐ **No**

_____

_____

2. Have you ever missed work for longer than 1 week due to a medical ailment? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

_____

_____

3. Please indicate those that apply:

☐ **Cancer** (provide pathology report if available)

Type and location: _____

Stage, level, grade: _____

Date of Treatment: _____

Type of Treatment: Chemo Radiation Surgical

☐ **Diabetes**

Date of diagnosis: _____

Treatment (diet only, oral tablets, insulin): _____

Date & result of last Hemoglobin A1C test: _____

Complications, if any: _____

Treated for:

Insulin reaction	Kidney trouble (albumin)
Diabetic coma	Neuritis, neuralgia, or neurotherapy
Eye trouble	Amputation
Heart trouble	Skin problems or infections
High blood pressure	Poor circulation or leg cramps

☐ **Heart Attack or Heart Disease**

Date of surgery: _____

Number of vessels involved: _____

Heart Attack? Yes No

Date & result of last stress test: _____

☐ **Drug / Alcohol Use**

Type of usage and amounts: _____

Date of first use and date stopped: _____

Rehab center – date admitted, date released: _____

Involved in AA or other support group and frequency: _____

Any recurrences with dates: _____

☐ **Nicotine Use** (including gum, patch, and electronic cigarettes)

Product(s): _____

Frequency (Daily, 1/month, etc.): _____

Date of last use: _____

☐ **Aviation as a Pilot**

Type of license including IFR: _____

Type of aircraft(s): _____

Total flight hours as a pilot: _____

Flight hours as a pilot in the last 12 months: _____

Flight hours as a pilot in the next 12 months: _____

☐ **Non-US Citizen**

VISA Type: _____

Date of entry into the US: _____

Country of citizenship: _____

4. Please list all medications (including over-the-counter) you have taken within the past 24 months and why:

_____

_____

5. Is any future surgery or medical treatment planned or recommended? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

_____

_____

6. Family History:	**Medical Condition** (Cancer, heart disease, diabetes, etc.)	**Age at Onset**	**Age if Living**	**Cause of Death**	**Age at Death**
Parent(s)					
Sibling(s)					

7. Have you ever traveled, or do you plan on traveling outside the U.S.? If "Yes", please provide details including destination(s), purpose, and length(s) of stay below. ☐ **Yes** ☐ **No**

_____

_____

8. Have you ever engaged in motor vehicle racing, SCUBA or sky diving, cliff or base jumping, mountain/ice/rock climbing, other similar activity, or plan to do so in the future? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

_____

_____

9. Please indicate those conditions for which you have ever received treatment (provide details below):

☐ Blood Pressure	☐ Asthma/Lung Disorder	☐ Crohn's Disease	☐ Rheumatoid or Psoriatic Arthritis
☐ Sleep Apnea	☐ Irregular Heart Beat	☐ Ulcerative Colitis	☐ Stroke or Transient Attack (TIA)
☐ Anxiety/Depression	☐ Hepatitis A, B, C	☐ High Cholesterol	☐ Other: _____

10. Have you ever been charged with a felony, DUI, DWI, reckless driving or has your driver's license ever been suspended? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

_____

_____

11. Have you ever declared bankruptcy? If "Yes", please provide details including chapter of bankruptcy, personal or business, cause, and date of discharge. ☐ **Yes** ☐ **No**

_____

_____

12. Is there any additional medical, financial, or activity history or intent that should be considered during the quoting process? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

_____

_____

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.