PERFORMANCE EVALUATION

for your life insurance policy

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 PERFORMANCE EVALUATION.

DATE	ADVISOR'S NAME	TELEPHONE NUMBER	EMAIL ADDRESS
		( )	

CLIENT INFORMATION

LEGAL NAME:				STATE OF RESIDENCE:
DATE OF BIRTH:	HEIGHT:	WEIGHT:	GENDER:	MARITAL STATUS:

CURRENT POLICY INFORMATION

Policy Owner Name: _____ **Policy Beneficiary Name:** _____

Face Amount: $ _____ **Cash Surrender Value:** $ _____

Annual Premium: $ _____ **Years Remaining to Pay Premium:** _____

Premium Expected to be paid Going Forward: $ _____ **Years Expected to Pay Premium:** _____

Coverage Type: ☐ **Whole Life** ☐ **Universal Life** ☐ **Variable Universal Life** ☐ **Other:** _____

CURRENT PURPOSE OF INSURANCE

☐ **Income Replacement** ☐ **Estate Taxes** ☐ **Buy-Sell** ☐ **Key Person** ☐ **Retirement Income**

☐ **Estate Equalization** ☐ **Executive Benefits** ☐ **Charitable Planning** ☐ **Other:** _____

OBJECTIVE(S) OF PERFORMANCE EVALUATION

☐ **Reduce Premium** ☐ **Increase Death Benefit** ☐ **Add or Extend Policy Guarantees**

☐ **Align Coverage with More Stable Carrier** ☐ **Other:** _____

HEALTH INFORMATION

1. Indicate those conditions for which you have ever received treatment:

☐ Cancer (of any kind) ☐ Heart Attack or Heart Disease ☐ Diabetes ☐ Drug or Alcohol Abuse

(For any indicated condition, please complete the following relevant section)

I. Cancer

Date of diagnosis and start of treatment: _____

Date released from treatment: _____

Type of treatment: ☐ Chemo ☐ Radiation ☐ Surgical

Type and location of cancer: _____

II. Heart Attack or Heart Disease

Date of surgery: _____

Number of vessels involved: _____

Current medication: _____

Was there a prior heart attack: ☐ Yes ☐ No

III. Diabetes

Date of diagnosis: _____

Treatment: diet only, oral tablets, Insulin: _____

Date and results of last Hemoglobin A1C test: _____

Complications, if any: _____

IV. Drug/Alcohol Questions

Type of drug or alcohol: _____

Date of first use and date stopped: _____

Involved in AA or other support group? ☐ Yes ☐ No

Any recurrences with dates: _____

Arrests for DWI or DUI: _____

HEALTH INFORMATION CONTINUED

2. Indicate those conditions for which you have ever received treatment (provide details below):

☐ Blood Pressure ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Depression ☐ Emphysema ☐ Hepatitis

☐ Epilepsy ☐ Heart Murmur ☐ Liver Disorder ☐ Lupus ☐ Urinary or Kidney Disorder

☐ Respiratory or Lung Disease ☐ Mental or Nervous Disorder ☐ Stroke or Transient Ischemic Attack

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

4. Have you ever used tobacco or other nicotine products (gum, patch, etc.)? If "Yes", please indicate type, frequency and last use. ☐ **Yes** ☐ **No**

5. List all current medications (including over-the-counter) you are currently taking:

6. If you participate in any hazardous avocations (flying as a private or student pilot, scuba diving, auto racing, mountain climbing, etc.) please provide details:

7. Provide details regarding any planned travel outside of the U.S. including destination(s) and length(s) of stay:

8. Did either of your parents or any of your siblings die from cardiovascular disease or cancer prior to the age of 60? If "Yes", please provide details below. ☐ **Yes** ☐ **No**

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

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.

Authorization for Release of In Force Policy Information

I hereby authorize BUI and its staff, including but not limited to Mickey Vogt and/or Kirsten Jaycox to obtain and/or request information as described on the attached letter regarding my existing life insurance policy(ies) listed below. This information shall include but not be limited to in force ledgers, premium basis, policy dates, cash values, interest/dividend history, and underwriting classifications.

The information collected will be held in confidence, but may be reviewed and assessed by qualified personnel consisting of medical, underwriting, and actuarial resources or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of **BUI** affiliated insurance companies and their reinsurers.

The records may be transmitted verbally, via U.S. regular mail, various overnight mail services, and/or the use of secured electronic devices.

This authorization shall be valid for six (6) 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 may revoke this authorization at any time and that the revocation will take effect when my representative receives my written request.

Insurance Carrier	**Coverage Type** **(Ex. Term, UL, VUL, Whole Life)**	**Policy Number**	**Issue Date**	**Insured Name**	**Birthdate**

Signed on the _____day of _____, the year _____ at _____
(City & State)

Print Policy Owner Name: _____

Policy Owner Social Security or Tax ID: _____

Policy Owner Address: _____

City: _____ State: _____ Zip Code: _____

Policy Owner Signature: _____