Informal Inquiry

Not an application for life insurance

LION STREET™
Owned by Fiercely Independent Advisors

PERSONAL HISTORY – PROPOSED INSURED

Name	☐ Male ☐ Female	Social Security #	
Address	City	State	Zip
Phone number	Date of Birth	Place of Birth	
E-mail address	Monthly Earned Income	Net Worth	
Drivers License Number	Drivers License State	Height	Weight

EMPLOYMENT

Occupation	Title	Employer	
Address	City	State	Zip
Business phone number	How long at current job?		

REQUESTED COVERAGE

☐ Universal life ☐ Survivorship ☐ Term ☐ Whole life ☐ Variable life	Face amount desired	Premium amount desired
Purpose of insurance	Will premiums be financed? ☐ Yes ☐ No ☐ Possibly	Will there be any 1035 money with this replacement? ☐ Yes, amount carried over: _____ ☐ No

Existing Insurance

Company	Type	Amount	Premium	Replacing
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NON-MEDICAL RISK

1. In the last five years have you, or do you plan to:
   a. Be a member of any armed forces or military unit? ☐ Yes ☐ No
   b. Pilot any type of aircraft? ☐ Yes ☐ No
   c. Engage in scuba/skin diving, motor vehicle racing, skydiving or any other hazardous sporting activity? ☐ Yes ☐ No
   d. Live outside the United States or Canada (If yes, explain on page 2) ☐ Yes ☐ No
   e. Travel outside the United States or Canada (If yes, explain on page 2) ☐ Yes ☐ No

2. In the last five years have you:
   a. Been in a motor vehicle accident, been charged with driving while intoxicated or had more than one moving violation? (If yes, explain on page 2) ☐ Yes ☐ No
   b. Been on parole or probation or charged with a felony or misdemeanor? (If yes, explain on page 2) ☐ Yes ☐ No

3. In the last ten years have you used any tobacco or nicotine products? ☐ Yes ☐ No
   (Indicate date last used and amount per day)
   a. ☐ Cigarettes _____
   b. ☐ Cigars _____
   c. ☐ Nicotine patch/gum _____
   d. ☐ Pipe _____
   e. ☐ Chewing tobacco/snuff _____
   f. ☐ Other _____

4. In the last ten years have you consumed alcoholic beverages? ☐ Yes ☐ No
   If yes, date last used? _____ Number of drinks per week: _____

5. In the last ten years have you used marijuana? ☐ Yes ☐ No If yes, ☐ Medicinal ☐ Social Use Frequency _____

6. In the last ten years have you used cocaine, methamphetamines, barbiturates or other controlled substances? ☐ Yes ☐ No

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE
THIS FORM IS HIPAA COMPLIANT

Informal Inquiry Part B

Not an application for life insurance

LION STREET™
Owned by Fiercely Independent Advisors

FAMILY HISTORY

	Age if living	Status of health	Age at death	Cause of death
Father				
Mother				
Brothers & Sisters Number Living Number Dead				

Has any family member listed above had cancer, diabetes, high blood pressure, heart disease, or kidney disease (past 7 years in Maryland)?

☐ Yes ☐ No If yes, under COMMENTS identify family member, disorder, age of onset. If there is a history of cancer, indicate type of cancer.

MEDICAL HISTORY

Name, address, and phone of primary care physician:	Date seen	Reason / Diagnosis
Other medical practitioners or health care providers you have consulted during the past five years: (See Physician List)		

MEDICAL RISK

If yes to the following questions, explain below.

1. In the past 10 years, have you ever been treated for or been diagnosed by a member of the medical profession or health practitioner ("health care provider") as having:
   a. Dizziness, seizures, convulsions, headache, paralysis, stroke, TIA, or a mental or nervous disorder, including anxiety or depression? ☐ Yes ☐ No
   b. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis, or chronic respiratory disorder? ☐ Yes ☐ No
   c. Chest pain, palpitations, high blood pressure, heart murmur, heart attack, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder? ☐ Yes ☐ No
   d. Jaundice, intestinal bleeding, ulcer, hepatitis, colitis, or other disorder of the stomach, intestine, liver, pancreas, or gall bladder? ☐ Yes ☐ No
   e. Sugar, albumin, or blood in urine, sexually transmitted disease, nephritis, stone, or other disorder of the kidneys, bladder, breasts, prostate, or reproductive organs? ☐ Yes ☐ No
   f. Diabetes, thyroid, or other endocrine disorder? ☐ Yes ☐ No
   g. Disorder of the skin of lymph glands, arthritis, or any disorder of the muscles, joints, nerves or bones? ☐ Yes ☐ No
   h. Anemia of any other disorder of the blood? ☐ Yes ☐ No
   i. A positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or any other disease or disorder of the immune system? ☐ Yes ☐ No
2. Have you:
   a. Had any operation(s) in the past 5 years? ☐ Yes ☐ No
   b. In the past 5 years been advised to have operation(s), treatments, or diagnostic tests that have not yet been performed? ☐ Yes ☐ No
   c. Had an electrocardiogram, x-ray, or other diagnostic test in the past 5 years? ☐ Yes ☐ No
   d. Sought or been advised by a health care provider to seek advice or treatment for the use of alcohol or drugs? (If "Yes", explain below) ☐ Yes ☐ No
   e. In the past 5 years been confined for observation, care, or treatment in a hospital or other health care facility? ☐ Yes ☐ No
   f. In the past 5 years consulted any health care provider(s), not already identified, for any reason including routine physical examination? ☐ Yes ☐ No
   g. Ever been diagnosed by a health care provider as having a tumor, pre-cancerous lesion or cancer? ☐ Yes ☐ No
3. Are you presently taking any medication(s), including non-prescription/over the counter medication or supplements? ☐ Yes ☐ No

COMMENTS

Please explain any "yes" answers to Medical risk questions:

Physician List
Supplement

LION STREET℠
Owned by Fiercely Independent Advisors

Proposed Insured: _____

Date of Birth: _____ Social Security #: _____

Please provide us with the following information on your physicians so we may obtain the necessary medical records to submit with your application. Use additional pages if necessary.

DOCTOR #1

Doctor's Name			
Hospital or Firm Name		Phone number	
Address	City	State	Zip
Date Last Seen	Reason Last Seen		
Results/Diagnosis of Last Visit			

DOCTOR #2

Doctor's Name			
Hospital or Firm Name		Phone number	
Address	City	State	Zip
Date Last Seen	Reason Last Seen		
Results/Diagnosis of Last Visit			

DOCTOR #3

Doctor's Name			
Hospital or Firm Name		Phone number	
Address	City	State	Zip
Date Last Seen	Reason Last Seen		
Results/Diagnosis of Last Visit			

DOCTOR #4

Doctor's Name			
Hospital or Firm Name		Phone number	
Address	City	State	Zip
Date Last Seen	Reason Last Seen		
Results/Diagnosis of Last Visit			

THIS IS NOT AN APPLICATION FOR LIFE INSURANCE
THIS FORM IS HIPAA COMPLIANT

Authorization

to Obtain and Disclose Confidential Information

LION STREET™

This Authorization is HIPAA compliant.

Proposed Insured. _____

Date of Birth: _____ Social Security # _____

Records and Information obtained from the Proposed Insured or other parties may be disclosed to and between the insurance companies or the insurance agencies listed below, Lion Street, Inc., Lion Street Financial, LLC, Lion Street Advisors, Inc., Lion Street Insurance Services, Inc., Tellus Brokerage, Inc., Crump Life Insurance Services, Inc., brokers, contractors, employees, representatives and agents working for or through those entities for purposes of the Proposed Insured applying for or evaluating insurance coverage.

21st Services	New England Life Insurance Co.
AIG	New York Life Insurance and Annuity Co.
Allianz of North America	New York Life Insurance Co.
American General Life Insurance Co.	North American Co.
American National	One America/State Life
Ashar Group, LLC	Pacific Life and Annuity Co.
AXA Equitable Life Insurance Co.	Pacific Life Insurance Company
Banner Life	Pan-American Assurance Company
Better Health Advisors	Pan-American Life Insurance Group
Brighthouse Financial	Penn Insurance and Annuity Company
Companion Life	Penn Mutual Life Insurance Company
Continental Assurance (CNA) LTC	Peterson International Underwriters
Crown Global Insurance Group, LLC	Phoenix Life Insurance Co.
Crump Life Insurance Services, Inc.	Phoenix Variable Ins. Co
Disability Insurance Services, Inc.	Principal Financial
EMSI	Principal Life Insurance Company
Equus Financial Consulting, LLC	Principal National Life Insurance Company
ExamOne	Pro Offer (Risk Righter, LLC)
Exceptional Risk Advisors	Protective Life Insurance Co.
Exclusive Marketing Organization (EMO)	Protective of NY
Fasano Associates, Inc.	Pruco Life Insurance Co.
Genworth Life and Annuity	Pruco Life Insurance Co. of New Jersey
Genworth Life Insurance Co.	Prudential Insurance Co. of America
Genworth Life of New York	Prudential Life Insurance Companies
Global Atlantic Financial Group	ReliaStar Life Insurance Company
Global Financial & Insurance Services	ReliaStar Life Insurance Company of New York
Great West Life	Resolution Life
Guardian Life	Securian Life Insurance Company
Hartford Life and Annuity Insurance Co.	Security Life of Denver Insurance Company
Hartford Life Insurance Co.	Sun Financial
Jetstream APS	Sun Life Assurance Co. of Canada
John Hancock Life U.S.A.	Sun Life Insurance and Annuity Co. of NY
John Hancock New York	Sun Life Insurance Co. of America
Legal & General America	Superior Mobile Medics
Life of the Southwest	Symetra Life Insurance Company
Lincoln Life	Tellus Brokerage, Inc.
Lincoln Life & Annuity Co. of New York	TIAA -Cref
Lombard International	Transamerica Financial Life Insurance
M3 Financial	Transamerica Life Insurance Company
Mass Mutual Life Insurance Company	Union Central Insurance
Met Life	United of Omaha
Met Life Investors USA Insurance	United States Life
Minnesota Life Insurance Company	West Coast Life Ins Co.
Mutual of Omaha	William Penn of New York
National Life of Vermont	Zurich American Life Insurance Company
Nationwide Life and Annuity Co. of America	Zurich American Life Insurance Company of New York

Agent Name: _____ Physician(s): _____

Agency Name: _____ Facility/Hospital(s): _____

The purpose of this Authorization is to assist in the evaluation and placement of my application for insurance. I hereby authorize the release of any information and all records regarding me, the proposed insured, pursuant to this Authorization. This includes, without limitation, any and all records and protected health information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition, with the exclusion of psychotherapy notes. Such records and information to be released may include, but are not limited to, facts about my: (1) mental & physical health; (2) alcohol/drug abuse treatment, (3) pharmacy prescriptions, (4) HIV testing & treatment, except where prohibited by law, (5) sexually transmitted diseases, (6) Sickle Cell testing & treatment, (7) laboratory test results, (8) other insurance coverage, (9) hazardous activities, (10) character, (11) general reputation, (12) mode of living, (13) finances, (14) occupation, and (15) other personal traits.

I understand that any Insurer or Agency named afore, its reinsurers, and insurance support organizations, and those persons authorized to represent them may need to collect such information for proposed insurance coverage. The Insurers and Agencies named afore and their reinsurers will use the information in order to determine whether I am insurable or to assist in the application and underwriting process. The insurance producer may also use this information to help update and improve my insurance program.

I hereby authorize any medical practitioner, including my primary care physician, any medical facility, health plan, health care professional, laboratory, other medical entity, insurance support organization, financial institution, consumer reporting agency and my employer, to give the information described above to the Insurers and Agencies listed afore.

I understand that my information will be kept confidential, and will not be disclosed to other persons or organizations without this written permission for the purposes referenced herein, except to the extent that it is necessary for (1) the Insurers and Agencies named afore and their reinsurers and other entities required to conduct business; (2) other insurers to which I have applied or may apply; (3) reinsurers; or (4) other persons whom perform business, professional or insurance services for them. They may also disclose this information as allowed by law. I understand that the Agencies and Insurers listed afore may use secured internet-based systems to store and access some or all of the confidential and personal medical information.

I understand that when information is used or disclosed pursuant to this Authorization, it may be subject to redisclosure by the insurance company and may no longer be protected by the federal and state laws and regulations that may have applied in the first instance. This Authorization will remain in effect for 24 months from the date of my signature below.

I understand I may revoke this Authorization at any time by requesting such of my agent/broker in writing and sent to the healthcare provider, if required. I understand that such revocation would not be effective to the extent any of the parties herein have already relied upon this authorization.

A photocopy of this Authorization is as valid as an original. I acknowledge that I have received a copy of this Authorization and the Notice to Proposed Insured(s). If minor children are proposed for coverage, the above statements are made by the person authorized to act on their behalf.

I understand that I am not required to sign this Authorization. I understand, however, that if I do not sign this Authorization to release my records and information that the insurers and agencies listed herein may not be able to evaluate and place my application for insurance. I understand that any health care provider who receives this authorization will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

Signed at _____ (city, state) this _____ day of _____, _____ (year)

Proposed Insured's Signature: _____

Print name of Proposed Insured: _____ Social Security # _____

Complete if Minor Child is Proposed for Coverage:

Name of Minor Child: _____

Relationship of Representative to Minor: _____

Signature of Witness: _____

Signature(s) of Policy Owner(s): _____

Notice to Proposed Insured

LION STREET™

Instructions to the Producer: This notice must be given to the proposed insured before or at the time of signature.

Federal Fair Credit Reporting Act Notice

Federal law requires that you be advised that in connection with your application or informal inquiry concerning insurance an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This report would include information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. If you make a written request to any of the insurers named on the reverse side within a reasonable time after receipt of this notice, you will be informed whether or not an investigative consumer report was requested, and if such a report was requested, you will be advised of the name and address of the consumer reporting agency to whom the request was made. The consumer reporting agency, upon request, will furnish information as the nature and scope of its investigation. You have the right to inspect and to receive a copy of any such report by contacting the consumer reporting agency.

The Medical Information Bureau (MIB)

A source of information and medical records, MIB is a non-profit insurance support corporation which operates an information exchange on behalf of member life insurance companies. Member companies will ask the MIB if it has a record concerning you. If you previously applied to a member company for insurance, MIB may have information about you in its file. The purpose of the MIB is to protect member companies and their policy owners from those who would conceal significant facts relevant to their insurability. The information which is obtained from MIB may be used only as an alert to the possible need for further independent investigation. It cannot be used as a basis in making a final underwriting decision.

At your request, the MIB will arrange disclosure of any information it may have about you in its file. If you question the accuracy of information on file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the information office of MIB, Inc. is PO Box 105, Essex Station, Boston Massachusetts 02112, telephone number: 612.426.3660.

Notice of Insurance Information Practices

In the course of properly underwriting and administering your insurance coverage, the insurers named on the reverse side will rely primarily on information provided by you. They may also seek information from others, such as medical professionals who have treated you. In some cases, they
may ask a consumer reporting agency to collect information and submit an investigative consumer report to them. This also authorizes the preparation of an investigative consumer report. You have the right to request to be interviewed in connection with the preparation of that report. The consumer reporting agency will make the contents of that report available to you in accordance with federal law.

In some situations, and in compliance with applicable law, the consumer reporting agency may disclose necessary items of information to the parties without your specific authorization.

You have the right to be told about, and to see and copy if you wish, items of personal information about you that appears in their files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE NAMED INSURERS AND YOUR AGENT'S INFORMATION PRACTICES.

EACH INSURER NAMED HEREIN REQUIRED THE COMPLETION OF A FULL APPLICATION OF ITS RESPECTIVE PRODUCT LINES.

Baylor Scott & White HEALTH

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Baylor Scott & White Health to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form.

I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company or non-health care provider, the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or event specified here _____ (Expiration date/event).

I further understand that I may revoke this authorization at any time by notifying, in writing, the Baylor Scott & White Health facility where this authorization is being signed. I also understand the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

I understand there is a charge for photocopies and records provided on electronic media, as permitted by Texas law, unless copies are sent directly to another health care provider. ☐ I would like to review my record

Patient Name	Last 4 of Social Security Number	Date of Birth MM / DD / YYYY	Acct #	MRN
Street Address	City State	Zip	Telephone Number	

Please release information from these BSWH facilities: _____

Please release the following information for these treatment dates: _____

The information will be released to: ☐ Patient/Designee ☐ Health Care Entity ☐ Insurance Company ☐ Attorney ☐ Other

Individual/Organization Name		Telephone Number
Street Address	City, State, Zip	Fax Number

Purpose of the use and/or disclosure: ☐ Continued Care ☐ Legal ☐ Insurance ☐ Personal Use ☐ Other _____

Record copy format: ☐ Paper ☐ CD ☐ _____ **Record copy delivery:** ☐ Pick-up ☐ Mail ☐ Fax to healthcare office

Information to be released:

Include this information if applicable: _____ Alcohol/Drug (PT INITIALS) _____ Genetics (PT INITIALS) _____ HIV/AIDS (PT INITIALS) _____ Mental Health (PT INITIALS)

☐ Summary Abstract only (clinic notes, history/physical, procedure reports, pathology, consultations, test results, discharge summary)

☐ Emergency Department	☐ Discharge Summary	☐ Medication	☐ Provider Orders
☐ Billing Record	☐ History/Physical	☐ Nurses' Notes	☐ Radiology Film
☐ Complete Chart	☐ Immunization	☐ Operative Reports	☐ Radiology Reports
☐ Consultations	☐ Laboratory	☐ Progress Notes	

☐ Other: _____

I understand the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

_____ _____

Signature of Patient or Legal Representative (electronic signatures not acceptable) Date

_____ _____

Printed Name of Patient or Legal Representative Relationship to Patient

_____

Representative's Authority to Act for Patient
(attach supporting documentation)

LION STREET

INDIVIDUAL LIFE TRANSMITTAL

REQUIRED

Client Information:

ver. 11062018

Date:_____

1st Insured	2nd Insured
First Name	First Name
Last Name	Last Name
DOB	DOB
SSN	SSN
Class Applied For	Class Applied For
☐Male ☐Female	☐Male ☐Female

Firm Information:

Sally Engelbrecht
Case Manager
254-399-0212
Case Manager Phone
sally@stibawmg.com
Case Manager Email
Stiba Wealth Management
Firm Name
Eric A. Stiba
Agent Name
465-99-4294
Agent SSN
400 Austin Ave. Suite 200
Firm Address
Waco, TX 76701
Firm City, State, Zip
(Send All Policies Here)

REQUIRED

Carriers and Coverage:

☐Formal
☐Informal
Face Amount _____ Product Type _____

☐Replacement
1035?☐Yes ☐No
Product Name _____ Application State _____

☐ Accordia – Global Atlantic: 0000006600
☐ Allianz: 753000100
☐ American General: 0BB223
☐ US Life NY: G3200
☐ AXA: 861078
☐ John Hancock: 741131
☐ John Hancock NY: 744970
☐ Lincoln Financial: 2328235
☐ Mass Mutual: 157
☐ Brighthouse MetLife: 4335-4023-189497-006
☐ Minnesota Life: 6004-477
☐ Mutual of Omaha: 584187
☐ National Life Group: 4SX
☐ Nationwide: H12256256
☐ New York Life: 110217
☐ North American: P8999
☐ Pacific Life: 02A2E0
☐ Penn Mutual: 900-S0339
☐ Principal: 01248-0065
☐ Protective: T01K946
☐ Protective NY: 000TA6H612
☐ Prudential: A89M4Y
☐ ReliaStar Life Ins. Co. of NY: 6Z709
☐ Security Life of Denver Ins. Co.: 286182
☐ Symetra: 06-34-7288
☐ Symetra NY: 06-34-7286
☐ Transamerica: 14127-114581
☐ Zurich: B00215
☐ Zurich NY: B00215NY
☐ Other:_____

Special Instructions:

☐Multi-Life
Business Name:_____
☐Premium Finance
☐Lion Street Underwriting Review
☐Quick Quote
☐Foreign National

IN GOOD ORDER

Informal Case:

☐ Lion Street HIPAA
☐ APS
Dr. Name: _____
Dr. Name: _____
Dr. Name: _____
☐ Informal Inquiry Form

Formal Case:

☐ Validate Agent Carrier Contract & State License(s)
☐ Signed Carrier Application
☐ Signed Carrier HIPAA
☐ Agent Report
☐ Regulation 60 (NY cases only)
☐ B/D or OSJ Approval (if variable)

Other Applicable Requirements:

Encl. Forthcoming
☐ ☐ **Risk Righter**
☐ ☐ Illustration (for permanent products)
☐ ☐ APS ☐ ***Agent to Order*** ☐ Carrier to Order
Dr. Name: _____
Dr. Name: _____
☐ ☐ Examination Report
Date:_____ Carrier:_____
☐ ☐ Lab Slip (Please Pull Labs)
Ticket #: _____ Date:_____
☐ ☐ HIV Consent Form
☐ ☐ Inspection Report ☐ ***Agent to Order*** ☐ Carrier to Order
☐ ☐ EKG Date:_____
☐ ☐ Financial Statements ☐ Carrier Form ☐ 3rd Party Verified

LION STREET

INDIVIDUAL LIFE TRANSMITTAL

REQUIRED

Client Information:

ver. 11062018

Date: _____

1st Insured	2nd Insured
First Name	First Name
Last Name	Last Name
DOB	DOB
SSN	SSN
Class Applied For	Class Applied For
☐ Male ☐ Female	☐ Male ☐ Female

Firm Information:

Sally Engelbrecht
Case Manager
254-399-0212
Case Manager Phone
sally@stibawmg.com
Case Manager Email
Stiba Wealth Management
Firm Name
Ernest A. Stiba, Jr.
Agent Name
457-96-1730
Agent SSN
400 Austin Ave. Suite 200
Firm Address
Waco, TX 76701
Firm City, State, Zip
(Send All Policies Here)

REQUIRED

Carriers and Coverage:

☐ Formal
☐ Informal
Face Amount _____ Product Type _____

☐ Replacement
1035? ☐ Yes ☐ No
Product Name _____ Application State _____

- ☐ Accordia – Global Atlantic: 0000006600
- ☐ Allianz: 753000100
- ☐ American General: 0BB223
- ☐ US Life NY: G3200
- ☐ AXA: 861078
- ☐ John Hancock: 741131
- ☐ John Hancock NY: 744970
- ☐ Lincoln Financial: 2328235
- ☐ Mass Mutual: 157
- ☐ Brighthouse MetLife: 4335-4023-189497-006
- ☐ Minnesota Life: 6004-477
- ☐ Mutual of Omaha: 584187
- ☐ National Life Group: 4SX
- ☐ Nationwide: H12256256
- ☐ New York Life: 110217
- ☐ North American: P8999
- ☐ Pacific Life: 02A2E0
- ☐ Penn Mutual: 900-S0339
- ☐ Principal: 01248-0065
- ☐ Protective: T01K946
- ☐ Protective NY: 000TA6H612
- ☐ Prudential: A89M4Y
- ☐ ReliaStar Life Ins. Co. of NY: 6Z709
- ☐ Security Life of Denver Ins. Co.: 286182
- ☐ Symetra: 06-34-7288
- ☐ Symetra NY: 06-34-7286
- ☐ Transamerica: 14127-114581
- ☐ Zurich: B00215
- ☐ Zurich NY: B00215NY
- ☐ Other: _____

Special Instructions:

☐ Multi-Life
Business Name: _____

☐ Premium Finance
☐ Lion Street Underwriting Review
☐ Quick Quote
☐ Foreign National

IN GOOD ORDER

Informal Case:

- ☐ Lion Street HIPAA
- ☐ APS
  - Dr. Name: _____
  - Dr. Name: _____
  - Dr. Name: _____
- ☐ Informal Inquiry Form

Formal Case:

- ☐ Validate Agent Carrier Contract & State License(s)
- ☐ Signed Carrier Application
- ☐ Signed Carrier HIPAA
- ☐ Agent Report
- ☐ Regulation 60 (NY cases only)
- ☐ B/D or OSJ Approval (if variable)

Other Applicable Requirements:

Encl. Forthcoming

- ☐ ☐ **Risk Righter**
- ☐ ☐ Illustration (for permanent products)
- ☐ ☐ APS ☐ ***Agent to Order*** ☐ Carrier to Order
  - Dr. Name: _____
  - Dr. Name: _____
- ☐ ☐ Examination Report
  - Date: _____ Carrier: _____
- ☐ ☐ Lab Slip (Please Pull Labs)
  - Ticket #: _____ Date: _____
- ☐ ☐ HIV Consent Form
- ☐ ☐ Inspection Report ☐ ***Agent to Order*** ☐ Carrier to Order
- ☐ ☐ EKG Date: _____
- ☐ ☐ Financial Statements ☐ Carrier Form ☐ 3rd Party Verified