THE TOLI GROUP

Protecting tomorrow's tomorrow.

UNDERWRITING ADVOCACY – PURE Medical Questionnaire

Informal Inquiry

PLEASE SEND THE COMPLETED INQUIRY **VIA EMAIL** TO: CPEPE@TOLIGROUP.COM | **VIA FAX** TO: 866.240.7557
OR **VIA MAIL** TO: ATTENTION UNDERWRITING DEPARTMENT | 2035 CROCKER RD. STE. 105 | WESTLAKE, OH 44145

MEMBER OFFICE INFORMATION

Agent Name: _____ **Phone:** _____ **Email:** _____

PLAN INFORMATION

Type of Insurance: ❑ TERM ❑ UL ❑ VUL ❑ SURVIVORSHIP

Face Amount Desired: _____

Planned Premium: _____

CLIENT INFORMATION

PROPOSED INSURED 1 (PI #1)

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ **DOB:** _____/_____/_____

SS#: _____ - _____ - _____ ❑ Male ❑ Female

Phone Number: (_____) _____ - _____

Resident State: _____

Height: _____ ft _____ In **Weight:** _____ lbs

Is your cholesterol above 220? ❑ Yes ❑ No

Is your blood pressure above 140/85? ❑ Yes ❑ No

PROPOSED INSURED 2 (PI #2)

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ **DOB:** _____/_____/_____

SS#: _____ - _____ - _____ ❑ Male ❑ Female

Phone Number: (_____) _____ - _____

Resident State: _____

Height: _____ ft _____ In **Weight:** _____ lbs

Is your cholesterol above 220? ❑ Yes ❑ No

Is your blood pressure above 140/85? ❑ Yes ❑ No

Do you currently, or have you ever used any form of tobacco in the last ten (10) years? (Cigars, cigarettes, chew, patch, gum, pipe)

Proposed Insured #1: ❑ Yes ❑ No | **If yes, what type?** _____ **Last Used:** _____/_____/_____

Proposed Insured #2: ❑ Yes ❑ No | **If yes, what type?** _____ **Last Used:** _____/_____/_____

PENDING AND IN-FORCE LIFE INSURANCE COVERAGE

PI #	COMPANY	FACE AMOUNT	TO BE REPLACED	1035 EXCHANGE	Policy Cash Value	1ST YEAR PREMIUM
		$	❑ YES ❑ NO	❑ YES ❑ NO		
		$	❑ YES ❑ NO	❑ YES ❑ NO		
		$	❑ YES ❑ NO	❑ YES ❑ NO		
		$	❑ YES ❑ NO	❑ YES ❑ NO		

DRIVING HISTORY AND AVOCATIONS

	PI #1	PI #2
	YES | NO	YES | NO
1. Have you had any DWI/DUI or reckless driving charges within the past five (5) years?	❑ ❑	❑ ❑
2. Are you a pilot, other than for a commercial passenger airline?	❑ ❑	❑ ❑
3. Do you engage in automobile or motorcycle racing, parachuting, skin or scuba diving, hang gliding, bungee jumping or any other hazardous sport?	❑ ❑	❑ ❑
4. Do you plan to travel outside the United States within the next twelve (12) months?	❑ ❑	❑ ❑

If YES was selected for any of the above, please provide details. _____

_____

CLIENT MEDICAL HISTORY

	PI #1	PI #2
	YES | NO	YES | NO
5. Do you have a personal history of cancer?	❑ ❑	❑ ❑
6. Do you have a personal history of heart disease?	❑ ❑	❑ ❑
7. Do you have a personal history of any other medical condition for which you are currently receiving, (and/or have received) treatment?	❑ ❑	❑ ❑
8. Do you have any family history (parents or siblings) of cardiovascular or cancer disease / death prior to age 60?	❑ ❑	❑ ❑

If YES, please provide details below.

PI #	RELATIONSHIP	DIAGNOSIS	AGE OF DIAGNOSIS	AGE OF DEATH

	PI #1	PI #2
	YES | NO	YES | NO
9. Are you currently taking any medications?	❑ ❑	❑ ❑

If YES, please provide details below.

PI #	NAME OF MEDICATION	DOSAGE	FREQUENCY	NAME OF PRESCRIBING PHYSICIAN

ALL PHYSICIANS SEEN FOR ANY REASON

Please list **ALL** doctors seen in the last five (5) years. Also, please list **ANY** doctor seen in the last ten (10) years for medical treatment related to cancer or cardiac (heart/esophageal) issues.

❑ PI #1 ❑ PI #2 | Date last seen: ____________________ Medical Diagnosis: ________________________________

Physician Name: ________________________________ Office Name: ________________________________

Address: ________________________________ City ____________________ State _____ Zip __________

Phone: (____) _____ - ________ Fax: (____) _____ - ________ For what condition did you visit this physician? ____________

____

❑ PI #1 ❑ PI #2 | Date last seen: ____________________ Medical Diagnosis: ________________________________

Physician Name: ________________________________ Office Name: ________________________________

Address: __________ ____________________ City ____________________ State _____ Zip __________

Phone: (____) _____ - ________ Fax: (____) _____ - ________ For what condition did you visit this physician? ____________

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❑ PI #1 ❑ PI #2 | Date last seen: ____________________ Medical Diagnosis: ________________________________

Physician Name: ________________________________ Office Name: ________________________________

Address: __________ ____________________ City ____________________ State _____ Zip __________

Phone: (____) _____ - ________ Fax: (____) _____ - ________ For what condition did you visit this physician? ____________

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Physician Name: ________________________________ Office Name: ________________________________

Address: __________ ____________________ City ____________________ State _____ Zip __________

Phone: (____) _____ - ________ Fax: (____) _____ - ________ For what condition did you visit this physician? ____________

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Physician Name: ________________________________ Office Name: ________________________________

Address: __________ ____________________ City ____________________ State _____ Zip __________

Phone: (____) _____ - ________ Fax: (____) _____ - ________ For what condition did you visit this physician? ____________

____

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Physician Name: ____________________ Office Name: ____________________

Address: __________ ____________________ City ____________________ State _____ Zip ________

Phone: (_____) _____ - ________ Fax: (_____) _____ - ________ For what condition did you visit this physician? ______________

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Physician Name: ____________________ Office Name: ____________________

Address: __________ ____________________ City ____________________ State _____ Zip ________

Phone: (_____) _____ - ________ Fax: (_____) _____ - ________ For what condition did you visit this physician? ______________

____

UNDERWRITING ADVOCACY – PURE Medical Questionnaire

Authorization to Obtain & Disclose Information

PATIENT INFORMATION

Name: _____ Birthdate:_____ /_____/_____ SS#:: _____ - _____-_____

PRINT NAME OF PATIENT

INFORMATION TO BE RELEASED FROM:

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, life settlement underwriter (life expectancy provider), life settlement provider, or other organization, institution or person, that has any records or knowledge of me or my health, to give such information to any of the life insurance companies or their reinsurers, life settlement underwriters, life settlement providers or other financial services intermediaries listed on this notice.

NAME OF DESIGNATED FACILITY OR PROVIDER ADDRESS

INFORMATION TO BE SENT TO:

To facilitate rapid submission of information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any of the companies listed below in this section. Mail to:

NAME OF RECORDS PROCUREMENT SERVICE STREET ADDRESS CITY | STATE ZIP TELEPHONE NUMBER

This service is acting on behalf of Executive Insurance Agency / ValMark Securities, Inc (ValMark). 130 Springside Dr., Suite #300, Akron, Ohio 44333 (800) 765–5201 and information may be released to ValMark or any of the financial services entities represented by ValMark Securities:

Abacus Settlements, American General, American National, AVS Underwriting, AXA, Banner Life, BMI Financial, CMG Surety, Coventry First, Credit Suisse, EMSI, Fairmarket LS Corp., Fasano Associates, Genworth, Great West Growth, Habersham Funding, Hartford, Independent Funding, ING, Jefferson Pilot, John Hancock, Legacy Benefits, Life Equity, Life Policy Traders, Life Settlement International, Life Settlement Leads, Life Settlement Providers, Life Settlement Solutions, Lifeline Program, Lincoln Benefit, Lincoln Life, Longmore Capital and its Affiliates, Magna Administrative Services, Maple Life, Met Life Investors, Milestone Providers LLC, Minnesota Life, Mutual of Omaha, Nationwide, New York Life, Pacific Life, Peachtree, Phoenix, Portsmouth, Principal, Proverian, Prudential, Q-Capital, Standard, Sun Life, Transamerica, United of Omaha, Vespers Financial Group, West Coast Life, 21st Services

INFORMATION TO BE RELEASED:

❑ The most recent five (5) years of pertinent information (Chart notes, labs, x-rays and special tests)

❑ Specific information: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released unless initialed below. To exclude any of the following information from the records released, please initial.

_____ Drug/alcohol abuse/treatment and diagnosis

_____ Sexually transmitted disease

_____ HIV/AIDS diagnosis/treatment/testing

_____ Mental illness or psychiatric diagnosis/treatment

PURPOSE FOR WHICH DISCLOSURE IS BEING MADE | PLEASE CHECK ONE OF THE FOLLOWING:

❑ Insurance ❑ Attorney ❑ Physician ❑ Personal

MY RIGHTS:

This authorization shall remain in force for 180 days following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to Executive Insurance Agency/ValMark Securities, Inc. 130 Springside Drive, Suite 300, Akron, Ohio, 44333. However, any action taken in reliance on this authorization prior to the notice of revocation shall be valid. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed except as authorized by me or as required by law. I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the financial services entity(ies) listed may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand I will receive a copy of this authorization upon request.

SIGNATURE OF PATIENT*: _____ DATE:_____

* If guardian or authorized representative, print name below signature and provide documentation to prove authority to sign on behalf of patient.

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ValMark Securities - Privacy Notice

YOUR PRIVACY IS VALMARK'S HIGHEST PRIORITY

At ValMark Securities, Inc. and its affiliated companies, our customers are our highest priority. As providers of financial products and services that involve the collection of personal – and often sensitive – information, protecting the confidentiality of that information has been, and will continue to be, a top priority for ValMark. Due to the sensitive nature of this personal information, ValMark believes that you should know how your information is handled, the measures we have taken to safeguard that information, and the situations in which we might share your information with select business partners. Our privacy promise to you is based upon the basic principles of trust, ethics and integrity.

THE INFORMATION COLLECTED BY VALMARK

When you work with one of ValMark's Member Offices, certain personal and financial information is collected from you. The information is used by ValMark to help serve your financial needs and to fulfill legal and regulatory requirements. The information gathered for these purposes varies depending on the products or services that you request but may include, for example, your name, address, social security number, net worth, annual income and certain medical information.

For both current and former customers, ValMark restricts access to your personal and financial information to those instances described below:

- *Employees of ValMark.* Your personal and financial information will be provided to those employees of ValMark who require the information to process the products or services being provided to you.
- *Companies with which ValMark* has selling agreements. ValMark will share your personal and financial information with other financial services entities, such as insurance companies and mutual fund companies, in order to effect transactions which you have requested or authorized. In such cases, those companies are prohibited, by agreement, from using information about you except for the narrow purpose for which it was given to them.
- *Other Companies as necessary to process your business.* Your personal and financial information will be provided to third-party administrators and vendors utilized by ValMark to effect, administer or enforce a transaction that you requested or authorized. For example, if you wish to purchase stocks, or bonds, ValMark processes that business through its clearing firm, RBC Dain Correspondent Services. ValMark must share your personal information with its clearing firm in order to process that business. These companies, like those in the category above, are prohibited, by agreement, from using information about you except for the narrow purpose for which it was given to them.
- *Where required by law or regulation.* ValMark may be required by law or regulation to disclose your personal and/or financial information to a third party. For example, in response to a subpoena or to comply with industry rules and regulations.
- As otherwise authorized or permitted by law. For example, the law permits ValMark to respond to requests for information about you from a consumer-reporting agency.
- *As authorized by you.* Only upon your direction or with your permission will ValMark share your information with a third party other than as described in this notice.

ValMark will not share your non-public information with any person or company that does not agree to keep your information confidential.

PROTECTION OF INFORMATION

ValMark has instituted security procedures that limit employee access to non-public personal information to those with a business reason for knowing such information. We educate our employees so that they will understand the importance of confidentiality and customer privacy. All ValMark employees are aware of the company's privacy guidelines and ValMark will take the appropriate disciplinary measures to enforce customer privacy assurances. ValMark maintains appropriate security standards and procedures to prevent unauthorized access to customer information and to preserve the integrity of that information.

VALMARK AFFILIATES

This Privacy Notice applies to the following companies affiliated with ValMark Securities, Inc.:

- ValMark Securities, Inc. – Broker Dealer and Member of FINRA and SIPC
- ValMark Advisers, Inc. – SEC Registered Investment Advisor
- Executive Insurance Agency, Inc. – General Agency for numerous insurance companies
- ValMark Insurance Agency, LLC