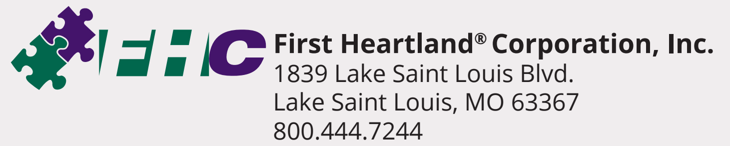
PRE

Preliminary Risk Evaluator



First Heartland® Corporation, Inc.
1839 Lake Saint Louis Blvd.
Lake Saint Louis, MO 63367
800.444.7244

Preliminary Inquiry - Not an application for life insurance

This TimeSaver form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Personal History (this section must be completed)

NAME

SEX ○ Male ○ Female

SOCIAL SECURITY NUMBER

ADDRESS

CITY

STATE

ZIP CODE

DATE OF BIRTH

AGE

HEIGHT

WEIGHT

MONTHLY EARNED INCOME

OCCUPATION

PHONE NUMBER

ARE YOU A US CITIZEN? ☐ Yes ☐ No

IF NO, STATE COUNTRY

DRIVERS LICENSE NUMBER

DRIVERS LICENSE STATE

TOBACCO / NICOTINE USAGE

HAVE YOU EVER SMOKED CIGARETTES? ☐ Yes ☐ No

IF YES, DATE OF LAST USAGE:

HAVE YOU USED OTHER TOBACCO OR NICOTINE CONTAINING PRODUCTS: ☐ Yes ☐ No

IF YES, PROVIDE TYPES AND LAST DATES OF USE:

Agent Information (this section must be completed)

NAME

SOCIAL SECURITY NUMBER

FHC REP #

ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

Requested Plan of Insurance (this section must be completed)

Minimum Consideration: $500,000 face amount and/or minimum premium of $2,500

☐ Universal Life ☐ Variable Life ☐ Whole Life ☐ Term, Level Period ______ ☐ Survivorship* ☐ Disability Income, Monthly Benefit Amount ______

FACE AMOUNT DESIRED

PREMIUM AMOUNT DESIRED ○ Annually ○ Monthly

WHAT WILL BE THE PURPOSE OF THE INSURANCE?

**Please have other proposed insured submit a separate PRE Form as well.*
Please provide details on pending and in-force coverage

COMPANY	POLICY/APPLICATION DATE	AMOUNT	CLASS/RATING ISSUED	CURRENT PREMIUM	DO YOU INTEND TO REPLACE?

ALL PAGES OF THE PRE FORM MUST BE COMPLETED. INQUIRY CANNOT BE CONSIDERED UNLESS AUTHORIZATION IS SIGNED AND INITIALED BY PROPOSED INSURED.

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PROPOSED INSURED	SOCIAL SECURITY NUMBER

Medical History (this section must be completed)

Question	DATE	ILLNESS
1. Who is your primary care physician? (Doctor's name, address, and phone number) When did you last consult him/her?		
2. What other physicians have you consulted during the past five years? (Do not include insurance examinations)		
3. In what hospitals, clinics, or other health facilities have you ever been treated?		
4. Please list all current medications		

Family History ☐ check here if this section does not apply

HAVE ANY IMMEDIATE FAMILY MEMBERS (PARENTS, SIBLINGS) BEEN DIAGNOSED OR DIED FROM HEART DISEASE OR CANCER? ☐ Yes ☐ No

If yes, please provide the following details:

RELATION	DIAGNOSIS	APPROXIMATE AGE DISEASE ONSET	(IF DECEASED) AGE OF DEATH

Drug and Alcohol Usage Questionnaire ☐ check here if this section does not apply

DO YOU CURRENTLY DRINK ALCOHOL? ☐ Yes ☐ No	DID YOU EVER DRINK MORE ALCOHOL THAN CURRENTLY? ☐ Yes ☐ No
DATE OF LAST CONSUMPTION	IF YES, WHEN?

TYPE	AMOUNT PER WEEK
BEER	
WINE	
LIQUOR	

TYPE	AMOUNT PER WEEK
BEER	
WINE	
LIQUOR	

HAVE YOU EVER CONSULTED A DOCTOR OR RECEIVED TREATMENT BECAUSE OF YOUR ALCOHOL USE? ☐ Yes ☐ No

HAVE YOU EVER BEEN ARRESTED FOR DRIVING UNDER THE INFLUENCE OF ALCOHOL? ☐ Yes ☐ No	IF YES, PROVIDE DATE(S):

HAVE YOU EVER SOUGHT MEDICAL TREATMENT BECAUSE OF DRUG USE OR HAS DRUG USE EVER BEEN A PROBLEM? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE DETAILS:

TYPE OF DRUGS USED:	DATE OF LAST USE

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PROPOSED INSURED | SOCIAL SECURITY NUMBER

Coronary ☐ check here if this section is not applicable

DATE OF DIAGNOSIS OR FIRST CHEST PAIN: | NUMBER OF DISEASED VESSELS:

DATES/DETAILS OF TREATMENT/SURGERY (EXAMPLES: ANGIOPLASTY, BYPASS)

DATE OF LAST STRESS EKG | RESULTS

BY WHOM?

ANY PAIN SINCE LAST TREATMENT/SURGERY?

Cancer ☐ check here if this section is not applicable

EXACT NAME AND LOCATION OF CANCER

STAGE AND GRADE

DO YOU HAVE THE PATHOLOGY REPORT?

DATES/DETAILS OF TREATMENT SURGERY

Diabetes ☐ check here if this section is not applicable

DATE OF DIAGNOSIS | TREATMENT ☐ Diet only ☐ Oral Medication ☐ Insulin

DETAILS

DO YOU REGULARLY TEST YOUR BLOOD GLUCOSE? | RESULTS | FREQUENCY

LATEST RESULT OF GLYCOHEMOGLOBIN (A I C) TEST: | DATE | HAVE YOU BEEN DIAGNOSED WITH HAVING PROTEIN AND/OR MI-CROALBUMIN IN YOUR URINE? ☐ Yes ☐ No

HAVE YOU EVER HAD: *(if yes, please provide details)*

- ☐ Eye trouble/diabetic retinopathy ____
- ☐ Kidney trouble/diabetic nephropathy ____
- ☐ Neuritis/neuralgia/diabetic neuropathy ____
- ☐ Insulin reactions/hypoglycemic episodes ____
- ☐ Foot trouble/diabetic ulcers ____
- ☐ Heart trouble ____
- ☐ High blood pressure ____

Foreign Travel and Residence ☐ check here if this section is not applicable

DO YOU PLAN TO TRAVEL OR RESIDE OUTSIDE THE US IN THE NEXT 3 YEARS? ☐ Yes ☐ No

IF YES, PLEASE PROVIDE THE COUNTRY/CITY/DATES/PURPOSE OF TRIP

Hazardous Activities ☐ check here if this section is not applicable

ARE YOU A PRIVATE PILOT? ☐ Yes ☐ No

IF YES, PROVIDE DETAILS BELOW:

How many total hours have you flown as Pilot in Command? ____

How many hours do you fly per year? ____

Have you an IFR (instrument flight rating)? ☐ Yes ☐ No

DO YOU PARTICIPATE IN THE FOLLOWING? (CHECK ALL THAT APPLY)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving

☐ Mountain Climbing ☐ Hang gliding ☐ Auto/Motorcycle Racing

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AGENT NAME

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB as part of our underwriting process, we or one of the insurance companies listed your authorization may request an investigative consumer information report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or others with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. Although an interview is normally conducted, you are entitled to make a specific request.

We keep such information reports confidential and use them only to evaluate and underwrite your application.

You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

Information received about you is treated confidentially and our employees take precautions to ensure that your information is safeguarded.

Upon receiving an executed Authorization, we may disclose information about you to persons or organizations performing business, professional, or insurance related functions on our behalf, insurance support organizations, or to any other person or organization to determine eligibility for insurance benefits, to detect fraud, misrepresentation, or material non-disclosure. We may also disclose information to accounting firms conducting audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interests.

Information may be disclosed to reinsurance companies, other insurance companies, your agents, and any other person or organization as may be permitted or required by law.

We may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which you may not be aware, or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies.

No medical record information or personal information relating to your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

You Can View and Correct Your Information

Generally, upon written request and to the extent permitted by law, you are permitted to review information which we have received about you. Please note that due to is sensitivity, you will not be permitted to view information received in connection with a claim or lawsuit. Also, if permitted by law, we may disclose information about your health only through your health care provider. If, upon review, you believe any information that we have received is incorrect, please notify us immediately. We will review and confirm the information provided. In the event such information is confirmed and you do not agree, you may offer an explanation in writing and we will include your statement when we give your information to anyone outside of First Heartland® Capital, Inc. or First Heartland® Corporation. If you want to know more about our privacy policy, please write us at 1837 Lake Saint Louis Boulevard, Lake Saint Louis MO, 63367.

PROPOSED INSURED'S SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE
PRINT NAME	NAME OF AGENT

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AGENT NAME

Authorization

This Authorization is HIPAA compliant.

PROPOSED INSURED

DATE OF BIRTH	SOCIAL SECURITY NUMBER

Purpose: The purpose of this Authorization is to permit First Heartland® Capital, Inc. ("FHCI") or First Heartland® Corporation ("FHC") to obtain and release non-public personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the Companies") listed below. Information that may be released to and disclosed by FHCI, FHC and the Companies listed below pursuant to this Authorization shall include any and all information, to the extent permitted by law.

Information to be Released: The information to be released pursuant to this Authorization includes any personal health information, records, or data concerning my past, present or future mental, physical or behavioral health or condition ("Information"), to the extent permitted by law.

Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medication prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits.

I understand that Information may also include results from blood, saliva, urine and other tests.

I further understand that Information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical tests results.

Authorization: I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person that has Information about me to release such Information to FHCI or FHC, and its authorized representatives.

I specifically authorize the Companies listed below to receive Information from and to release Information to FHCI or FHC. I also specifically authorize FHCI, FHC and the Companies listed below to release or redisclose Information about me to their reinsurers, underwriters or any other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to relate Information directly to any Company listed below upon such insurer's request, provided the insurer is a member of MIB. *

I understand that Information disclosed to FHCI or FHC may no longer be subject to state and federal privacy laws and regulations and may be subject to redisclosure. I understand that if I refuse to sign this Authorization to release my complete medical records, FHCI, FHC or the Companies may not be able to process my request.

I also authorize my Agent, named below, to receive Information and I authorize FHCI or FHC to disclose such Information to my Agent, to assist in the purpose of this Authorization to the extent permitted by law.

A photocopy of this Authorization shall be valid as the original.

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to FHCI or FHC at 1839 Lake Saint Louis Boulevard, Lake Saint Louis, MO 63367.

21st Services
Advance Settlements, Inc.
Advantage Insurance
Network Allianz Life Ins. Co.
American General Life
American National Ins.
Ameritas
Amerus
Assurity Life
Aviva Life
AXA Equitable Life
Banner Life
Genworth Life Ins. Co.
Guarantee Trust Life
Hartford Life Ins.
Indianapolis Life
ING Life & Annuity
ING Security Life of Denver
Jackson National
John Hancock Life Ins. Co. (U.S.A.)
John Hancock Variable Life Ins. Co.
John Hancock Life Ins. Co.
Life Insurance Company of the Southwest
Lincoln Life
Lincoln Benefit Life
Lincoln Life of NY
Lloyd's of London
Massachusetts Mutual Life
Metlife Investors
MetLife Investors USA
Metropolitan Life Ins. Co.
Midland National
Minnesota Life
Mutual of Omaha
National Life of Vermont
Nationwide
New York Life
North American Life & Health
North American Life & Health of NY
Old Mutual
Pacific Life
Pacific Life & Annuity
Penn Mutual
Phoenix
Presidential Life
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life
Prudential Ins. Co. of America
Pruco Life Ins. Co.
RBC (Liberty Life)
Reliastar
Security Mutual
Standard Life
Sun Life of Canada
Symetra
Transamerica
Transamerica Occidental
The United States Life Ins. Co. In the City of NY
United of Omaha
Union Central
West Coast Life
Zurich American Life

PROPOSED INSURED'S SIGNATURE (OR AUTHORIZED REPRESENTATIVE)	DATE
PRINT NAME	NAME OF AGENT

AUTHORIZED REPRESENTATIVE OF PROPOSED INSURED, IF APPLICALBLE

* MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with Information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for who coverage is sought If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask to correct the information as provided in the Federal Fair Credit Reporting Act. You can write to MIB, Inc., Post Office Box 105 Essex Station, Boston, MA 02112 or cal1 (617) 426-3660.

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