VALMARK SECURITIES

UNDERWRITING ADVOCACY

INFORMAL INQUIRY

PLEASE SEND THE COMPLETED INQUIRY VIA EMAIL TO: NEWCASE@VALMARKSECURITIES.COM | VIA FAX TO: (330) 576-1250 OR VIA MAIL TO: ATTENTION NEW BUSINESS | 130 SPRINGSIDE DRIVE, SUITE 300 | AKRON, OHIO 44333

MEMBER OFFICE INFORMATION

Agent Name: _____ Phone: _____ Email: _____

PLAN INFORMATION

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

Face Amount Desired: _____

Planned Premium: _____

Purpose of Insurance: _____

Rate Class Needed_____

CLIENT INFORMATION

PROPOSED INSURED 1 (PI #1)

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ DOB: _____/_____/_____

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

Phone Number: (_____) _____-_____

Resident State: _____

Driver's License Number & State _____

Height: _____Feet _____ Inches _____ Weight

PROPOSED INSURED 2 (PI #2)

Name: _____

Address: _____

City: _____ State: _____

Zip Code: _____ DOB: _____/_____/_____

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

Phone Number: (_____) _____-_____

Resident State: _____

Driver's License Number & State: _____

Height: _____Feet _____ Inches _____ Weight

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 YR PREMIUM
		$	❑ YES ❑ NO	❑ YES ❑ NO	$	$
		$	❑ YES ❑ NO	❑ YES ❑ NO	$	$
		$	❑ YES ❑ NO	❑ YES ❑ NO	$	$
		$	❑ YES ❑ NO	❑ YES ❑ NO	$	$

INFORMAL INQUIRY

CLIENT MEDICAL HISTORY

	PI #1		PI #2	
Do you have a personal history of any of the following conditions?	YES	NO	YES	NO
Cancer or tumors (*if yes, please complete supplement*)	❑	❑	❑	❑
Asthma, emphysema, obstructive sleep apnea, or COPD?	❑	❑	❑	❑
Depression, Anxiety, or other mental nervous condition?	❑	❑	❑	❑
Cardiovascular disorder, including heart attack, coronary artery disease, arrhythmia, valvular disease, heart murmur, cerebrovascular disease, stroke, or TIA? (*if yes, please complete supplement*)	❑	❑	❑	❑
Diabetes, elevated blood sugar, or glucose intolerance (*if yes, please complete supplement*)	❑	❑	❑	❑
Treatment or counseling for drug or alcohol use?	❑	❑	❑	❑
Any other health impairment or medically treated condition? _____	❑	❑	❑	❑
Have you had any medical tests, such as a treadmill stress test, X-Ray, MRI, heart scan, sleep study, or echocardiogram?	❑	❑	❑	❑
Do you have any family history (parents or siblings) of death prior to age 60 from cardiovascular disease or cancer?	❑	❑	❑	❑

Please provide full details to all "yes" answers, including the date of diagnosis, type of treatment, and doctors seen

PI #	DIAGNOSIS	YEAR	DOCTOR SEEN	TREATMENT

Are you currently taking any medications? If yes, please provide details below. ❑ ❑ ❑ ❑

PI #	NAME OF MEDICATION	DOSAGE	FREQUENCY	NAME OF PRESCRIBING PHYSICIAN

Do you drink alcohol? ❑ YES ❑ NO If yes, how many alcoholic drinks do you consume per week? _____

PERSONAL HISTORY

	PI #1 YES	PI #1 NO	PI #2 YES	PI #2 NO
Have you had any driving infractions, including moving violations, DUI/DWI, reckless driving, or license suspensions in the last 5 years?	❑	❑	❑	❑
Have you been rated or declined for life insurance in the past?	❑	❑	❑	❑
Are you a pilot, other than for a commercial passenger airline?	❑	❑	❑	❑
Do you engage in automobile or motorcycle racing, parachuting, skin or scuba diving, hang gliding, bungee jumping or any other hazardous sport?	❑	❑	❑	❑
Do you plan to travel outside the United States within the next twelve months?	❑	❑	❑	❑

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

____

ALL PHYSICIANS SEEN FOR ANY REASON

Please list **ALL** doctors seen in the last five years and **ANY** doctor seen in the last ten years for cancer or cardiac 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? _____________

❑ 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? _____________

PATIENT INFORMATION

Name: _____ Birthdate: _____/_____/_____ SS#: _____-_____-_____
PRINT NAME OF PATIENT

INFORMATION TO BE RELEASED FROM:

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, other health care provider, insurance company, life settlement underwriter (life expectancy provider), life settlement provider, or other organization, institution or person, that has provided payment, treatment or services to me or 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, life expectancy companies or other financial services intermediaries listed on this notice. I hereby authorize any company listed on this authorization to disclose any and all information related to my application to my writing agent and ValMark Securities.

The purpose of this disclosure is to provide my writing agent and ValMark Securities with the information necessary to provide me with ongoing advice and service. This protected health information is to be used or disclosed under this Authorization so that the Company and the Authorized Insurance Carriers listed below may: 1) underwrite my application for life and/or long term care insurance, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; 5) evaluate and obtain life settlement offer; and 6) conduct other legally permissible activities.

_____

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, ValMark Member Offices or any of the financial services entities represented by ValMark Securities:

Abacus Settlements, American General, American National, Aviva, APPS Paramedical Services, AVS Underwriting, AXA, Banner Life, Bear Stearns and Co., Berkshire Settlements, BMI Financial, Clinical Reference Laboratory, CMG Surety, Coventry First, Credit Suisse, EMSI, ExamOne, Fairmarket LS Corp., Fasano Associates, First Financial, Genworth, Great West Growth, Habersham Funding, Hartford, Independent Funding, ING, Jefferson Pilot, John Hancock, LabOne, Legacy Benefits, Life Equity, Life Plans, Life Policy Leads, Life Policy Traders, Life Settlement International, Life Settlement Leads, Life Settlement Providers, Life Settlement Solutions, Lifeline Program, Lincoln Benefit, Lincoln Life, Magna Administrative Services, Maple Life, Mass Mutual, Met Life Investors, Milestone Providers LLC, Minnesota Life, Mutual of Omaha, Nationwide, Nation's Care Link, New York Life, Pacific Life, Peachtree, Penn Mutual, Phoenix, Portsmouth, Portamedic/Hooper Holmes, Principal Life Insurance Company, Principal National Life Insurance Company, Protective, Proverian, Prudential, Q-Capital, RSA Medical, Silver Point Capital, The Standard, Sun Life, Transamerica, United of Omaha, ValMark Securities, 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: _____

Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing or treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

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.

PRIVACY NOTICE

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.

PLEASE GIVE THIS NOTICE TO THE PROPOSED INSURED

MEDICAL SUPPLEMENT

DETAILS ON CARDIOVASCULAR, CEREBROVASCULAR, OR CIRCULATORY DISORDERS

PI #	DISORDER	DATE OF DIAGNOSIS	TREATMENT (SURGERY, MEDS, DIET, ETC.)

Do you have any limitations, complications, or side effects from this disorder? If yes, please provide details.

_____

Have you had surgery for this condition? If yes, what surgery was completed? When was the surgery?

_____

When was your most recent cardiac testing? What type of test was completed? What were the results?

_____

DETAILS FOR CANCER HISTORY

PI #	DIAGNOSIS	DATE OF DIAGNOSIS	TREATMENT	DATE OF LAST TREATMENT	STAGE AND GRADE OF TUMOR

Did the tumor spread to involve any lymph nodes? If yes, how many? _____

Was there any metastasis of the tumor to other regions? _____

Has there been any evidence of recurrence? If so, please provide details

_____

DETAILS FOR DIABETES, ELEVATED BLOOD SUGAR, OR IMPAIRED FASTING GLUCOSE

PI #	DIAGNOSIS	DATE OF DIAGNOSIS	TREATMENT	MOST RECENT A1C AND BLOOD SUGAR READING	COMPLICATIONS (RETINOPATHY, NEUROPATHY, ETC.)

Please list additional doctors seen in the past 5 years and any doctors seen in the past 10 years for cancer or cardiovascular disease

❑ 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? _____________

❑ 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? _____________

Please list any additional medications taken

PI #	NAME OF MEDICATION	DOSAGE	FREQUENCY	NAME OF PRESCRIBING PHYSICIAN

11-2012