



**UNDERWRITING  
ADVOCATE**

Client Name: \_\_\_\_\_  
Client Phone Number: \_\_\_\_\_  
Client Email Address: \_\_\_\_\_  
Client Address: \_\_\_\_\_  
\_\_\_\_\_

Advisor Name: \_\_\_\_\_  
Advisor Phone Number: \_\_\_\_\_  
Advisor Email Address: \_\_\_\_\_  
Advisor Address: \_\_\_\_\_  
\_\_\_\_\_

1. What is the desired type of coverage and amount? (Life~Term or Permanent / Long Term Care / Disability)
2. Have you had a Needs Analysis completed? Would you like to have one done for the coverage requested?
3. Will the new policy replace any existing coverage? (Yes / No)
4. What is your date of birth?
5. What is your gender?
6. What is your height?
7. What is your weight in lbs.?
8. Have you EVER used any of the following tobacco products? Cigarettes, cigars, pipe, chewing tobacco. If so, select all that apply and when were they last used and how frequently?
9. Have any of your Parents or Siblings had an OCCURRENCE of the following conditions: heart disease, stroke, diabetes, or cancer? If so, please list the age they were diagnosed if they are still living, and their age at death if deceased.
10. Have you EVER been treated for cholesterol? If so, what medications and what is the dosage?
11. What is your total cholesterol? (example: 210)
12. What is your cholesterol ratio? (example: 4.5)

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email: [jcrone@cntwealth.com](mailto:jcrone@cntwealth.com)

ph: 770.517.1223

13. Have you EVER been treated for blood pressure? If so, what medications and what is the dosage?
14. What is your SYSTOLIC and DIASTOLIC blood pressure reading? (Number on top, example: **135/75**)
15. Have you EVER been convicted of a DWI, DUI, reckless driving, moving violation, license revocation or suspension? If so, when?
16. Have you EVER participated in any hazardous avocations? (Aviation, Climbing/Mountaineering, Gliding, Motor Sport, Parachuting, Scuba Diving, etc.) If so, how frequently?
17. Do you plan on traveling outside of the US or Canada? If so, where and for how long?
18. In the last 5 years, have you ever been treated for any other medical conditions or been asked to see a specialist? If yes, please list the reason.
19. Do you use a walker/wheelchair; oxygen, respirator, kidney dialysis; or need help in performing any of the following: Bathing, Dressing, Eating, Continenence; Walking or Transferring? If so, which?
20. Have you needed Home Health Care; Physical Therapy; Occupational Therapy or any type of Rehabilitation Program within the last 12 months? If so, for what reason?
21. Rate your overall attitude toward investments: Conservative = 1 and Aggressive = 10
22. What are your primary objectives:  Maximum insurance coverage  Growth of principal  Income  
 Safety of principal  Minimizing taxes  Pass assets to heirs

Please list names, phone numbers and addresses of your Doctors:

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**FINANCIAL AND MEDICAL RECORDS AUTHORIZATION**  
 (This authorization complies with the HIPAA Privacy Rule)  
 Give completed and signed copy to Proposed Insured

Name of Proposed Insured/Patient (please print) \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Name of Additional Proposed Insured/Patient (please print) \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

I authorize The Dempsey Companies, the agent/broker named below, Insurance support organizations (such as MIB, Inc.), the companies listed at the bottom and their reinsurers, agents employees and representatives to obtain medical and other information. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider, insurance company, the Medical Information Bureau, Inc., employer, consumer reporting agency, or other organization, institution or person that has information available as to my employment or other insurance coverage, or has provided payment, medical care, treatment, supplies, advice or services to me or on my behalf within the past 10 years ("My Providers") to disclose such information, including my entire medical record and any other protected health information concerning me to the individuals/entities named above. This includes information on diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose the entire medical record without restriction. This protected health information is to be disclosed under this Authorization at my request, as permitted by §164508(c)(1)(iv) of the Health Insurance Portability Act (HIPAA) Privacy Rules.

My protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage by making eligibility, risk rating, policy/certificate issuance and enrollment determination; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company(s).

This authorization shall remain in force for 24 months 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 sending a written request for revocation to The Dempsey Companies, 2951 Piedmont Road, Suite 200, Atlanta, GA 30305, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to My Providers. I understand that a revocation is not effective to the extent that any of My Providers have relied on this authorization or to the extent that the companies listed below have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as HIPAA Privacy Rule).

I understand that My Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, my application may not be processed, or if coverage has been issued benefit payments may not be made. I acknowledge that I have read and received a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured/Patient or Personal Representative \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Additional Proposed Insured/Patient or Personal Representative \_\_\_\_\_  
Date

If this authorization has been signed by a personal representative of the proposed insured/patient, please describe the basis for the personal representative's authority to act on behalf of the proposed insured/patient: \_\_\_\_\_  
 \_\_\_\_\_

Name of Agent/Broker \_\_\_\_\_ S.S.# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Companies to Which This Authorization Applies:**

<ul style="list-style-type: none"> <li>❖ Allstate Life Insurance Co. of NY</li> <li>❖ Advanced Settlements</li> <li>❖ American General Life</li> <li>❖ American National Life</li> <li>❖ AXA</li> <li>❖ Banner Life</li> <li>❖ Brokerage Resources of America, CPU</li> <li>❖ Cleveland Clinic</li> <li>❖ Coventry First</li> <li>❖ Dempsey Financial Network, Inc.</li> <li>❖ Exam One</li> <li>❖ EMSI</li> <li>❖ Exam One</li> <li>❖ Fidelity &amp; Guarantee</li> </ul>	<ul style="list-style-type: none"> <li>❖ Genworth Life and Annuity Insurance Co.</li> <li>❖ Genworth Life and Annuity Insurance Co. NY</li> <li>❖ Heather Milanese</li> <li>❖ Hooper Holmes</li> <li>❖ Jefferson Pilot Life</li> <li>❖ John Hancock</li> <li>❖ Lincoln Benefit Life</li> <li>❖ Lincoln Financial</li> <li>❖ Legacy Benefits Corp</li> <li>❖ Life Settlement Insights</li> <li>❖ Maple Financial</li> <li>❖ MetLife</li> <li>❖ The Principal</li> <li>❖ Portamedic</li> </ul>	<ul style="list-style-type: none"> <li>❖ Prudential</li> <li>❖ ReliaStar</li> <li>❖ Sun Life of Canada</li> <li>❖ Transamerica</li> <li>❖ West Coast Life</li> </ul>
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## UNINSURED PRODUCT DISCLOSURE AGREEMENT

I understand that this insurance product or annuity is not a deposit or other obligation of, or guaranteed by, First Cherokee State Bank (FCSB) or an affiliate of FCSB. In addition, the insurance product or annuity is not insured by the Federal Deposit Insurance Corporation (FDIC) or any other agency of the U.S., FCSB, or an affiliate of FCSB. In the event an insurance product or annuity involves investment risk, that risk includes the possible loss of value.

**By my signature below I acknowledge that I have read and understand the disclosure agreement listed above.**

Applicant/ Owner Signature \_\_\_\_\_ Date \_\_\_\_\_

Agent Signature \_\_\_\_\_ Date \_\_\_\_\_