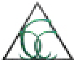


AIS

CARFAGNO INSURANCE SERVICES - Trial Submission Datasheet

Instructions on how to get the most out of your Informal Inquiries:

1.) In addition to the completed datasheet, **all inquiries and cases that are to be shopped Informally by Carfagno Insurance Services must include a signed Carfagno Insurance Services authorization form.** The form is the last page of the datasheet. Whether using this datasheet or submitting complete medical records, the authorization form must be submitted in all cases.

2.) Provide as much detail as possible. Keep in mind that this datasheet is intended to be used as an alternative to submitting full medical records on your informal business. The amount of detail you provide determines the information the underwriter has to consider. Providing more details lowers the possibility that you might leave something out which may have otherwise impacted the underwriter's decision.

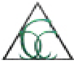
3.) Use the extra space provided. Each page has either a "Details" or "Other" section at the bottom. Use this area on the datasheet to add any information that may not have been asked for in any of the other questions.

4.) Whenever possible, and especially for financial underwriting or business insurance cases, provide a coverletter. In many circumstances, the best weapon we have when appealing a case to an underwriter is YOU - the agent. A detailed coverletter explaining the client's health history, lifestyle, and family history can help clarify a picture for an underwriter when a client has a complex medical history. Likewise, a coverletter discussing the relationships between owners, beneficiaries, corporations, etc. can help an underwriter to understand a sale based on an advanced marketing concept.

Please keep in mind that this form was developed by Carfagno Insurance to help us service your Informal business in a more efficient and timely manner. We still welcome and will accept Trials with Records and will shop them to our underwriters. This datasheet is an option we have made available to you to help you attain faster responses on your informal business. Though we feel that the information collected is valuable to an underwriter and can help us attain tentative offers for your clients more quickly than with the submission of full records, remember that **all offers received from Home Office underwriters on Informal business are tentative.** Regardless of if this datasheet was used, or full medical records were reviewed, any offer received as a result of an informal inquiry is dependant on full formal underwriting and is subject to change at the discretion of the underwriter.

Completed Trial Submission Datasheets should be faxed to AIS at (510) 893-4445 or e-mailed directly to your assigned case manager. If you have any questions or would like to discuss a case over the phone, call Doug Shimada at (800) 788-6524, ext. 125.

Created 7/5/2011



AIS

CARFAGNO INSURANCE SERVICES - Trial Submission Datasheet

Client Name:	Date of Birth:	Gender:
Type of Coverage:	Face Amount:	Agent:

REASON FOR INQUIRY (check all that apply)

- ☐ Medical History
- ☐ Foreign Travel
- ☐ Aviation
- ☐ Avocation
- ☐ Financial U/W
- ☐ Other

List all companies this file has already been sent to:

TOBACCO USAGE (only if applies)

- ☐ Cigarettes
- ☐ Other
- ☐ Cigars
- ☐ Quit: / /

OFFER NEEDED TO PLACE CASE

U/W Class:

Premium:

Complete this section if file is being shopped due to MEDICAL HISTORY

List all known Medications & Dosages

Medication:	*Dosage/ day:*

Attach a separate page if more space is needed

FAMILY HISTORY

Father
- Age (if living):
- Cause of Death:
- Age of Diagnosis:
- Age at Death:

Mother
- Age (if living):
- Cause of Death:
- Age of Diagnosis:
- Age at Death:

Sibling(s)
- Age (if living):
- Cause of Death:
- Age of Diagnosis:
- Age at Death:

BUILD

Height:

Weight:

List all known Medical Impairment(s) of Client:

Provide details below

CANCER

Type:
Date of Onset:
Staging:
Gleason Score:
Location of Tumor:
Size of Tumor:
Pre-treatment PSA:
Treatment:
Date of Treatment:
Post-treatment PSA:
Additional Details:

ASTHMA

Episodes:
Most Recent:
Frequency:
Known Causes:

Medications:
Steroids:
Frequency:

DIABETES

Type:
Onset Date:
Medication:
Controlled:
If yes, for how long?
Current A1c:

CORONARY ARTERY DISEASE

Date of Onset:
No. of Vessels:
Heart Attack:
Treatment:
Most Recent EKG:

ANXIETY / DEPRESSION

Onset Date:
Reason (i.e. stress, tramatic event):
Hospitalized:
If yes, date:

DRUG / ALCOHOL ABUSE

Current Use:
Last Use (date):
DUI / Arrest:
If yes, date:
Treatment:
Treatment Start:
Treatment End:

Provide Substances, Amounts and Frequency:

OTHER (provide as much detail as possible)

All u/w offers are tentative until a formal application has been submitted, underwritten, and approved.

<u>AIS</u>

CARFAGNO INSURANCE SERVICES - Trial Submission Datasheet

Complete this section if file is being shopped due to FOREIGN TRAVEL / RESIDENCE

PAST TRAVEL

Date(s):	Location(s):	Duration(s):

Attach a separate page if more space is needed

PLANNED (FUTURE) TRAVEL

Date(s):	Location(s):	Duration(s):

Attach a separate page if more space is needed

Purpose of Travel: ____________

Details: ____________

Location Description:

US Citizen: ____________

Details: ____________

Visa Type:

Complete this section if file is being shopped due to AVIATION

PURPOSE OF AVIATION ACTIVITY (check all that apply)

- [ ] Pleasure
- [ ] Military
- [ ] Student Instructor
- [ ] Test Flying
- [ ] Stunt Flying
- [ ] Commercial
- [ ] Business
- [ ] Charters
- [ ] Cropdusting
- [ ] Studen Pilot

LICENSES CURRENTLY HELD (check all that apply)

- [ ] Commercial Pilot
- [ ] Private Pilot
- [ ] Student Pilot
- [ ] IFR
- [ ] ATR

Type of plane:

Details:

HOURS FLOWN

Total Solo Hrs:	
Hrs. last year:	
Expected hrs. next 12 mos:	

Have you ever had an aviation accident / violation? ____________

Details: ____________

If necessary, which would you prefer? ____________

Extra Premium or Exclusion Rider

Additional Notes:

Complete this section if file is being shopped due to AVOCATION

S.C.U.B.A.

PURPOSE OF SCUBA ACTIVITY

- [ ] Dive for Pleasure
- [ ] Commerical Diver

DO YOU ENGAGE IN ANY OF THE FOLLOWING:

- [ ] Ice Diving
- [ ] Cave Dives
- [ ] Night Diving
- [ ] Search / Rescue
- [ ] Salvage Dives
- [ ] None of These

LOCATION(S) OF DIVES:

- [ ] Lakes
- [ ] Rivers
- [ ] Pools
- [ ] Ocean Beaches
- [ ] Deep Sea
- [ ] Other:__________

DIVING HISTORY

Depth	No. of Dives	Avg. Duration
Less than 50 ft.		
50-75 ft.		
76-100 ft.		
101-130 ft.		
131+ ft.		

OTHER, i.e. Racing, Skydiving, etc. (provide as much detail as possible):

All u/w offers are tentative until a formal application has been submitted, underwritten, and approved.

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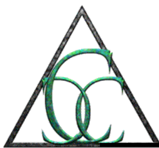
CARFAGNO INSURANCE SERVICES - Trial Submission Datasheet

Complete this section if file is being shopped for FINANCIAL UNDERWRITING					
ASSETS		LIABILITIES		Previous Year's Income:	
Cash:	$	Mortgages:	$	Current YTD Income:	
Real Estate (home):	$	Loans:	$	History of Bankruptcy?	
Real Estate (other):	$	Acct's Payable:	$	details:	
Business Equity:	$	Taxes Owed:	$		
Business Investments:	$	Other Loans:	$	Life Insurance currently In Force:	
Stocks and Bonds:	$	Total:	$ 0		
Personal Assets:	$				
Notes Receivable:	$	ASSETS:	$ 0		
Retirement Account(s):	$	LIABILITIES:	$ 0		
Total:	$ 0	NET WORTH:	$ 0		

If this file is being shopped for any reason not listed, provide as much detail as possible below:

All u/w offers are tentative until a formal application has been submitted, underwritten, and approved.



AIS & CARFAGNO INSURANCE SERVICES, INC.

A Principal Member of Insurance Designers of America

14220 Northsight Boulevard, Suite 145 Scottsdale, Arizona, 85260

AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION

This authorization complies with the HIPAA Privacy Rule.

Name of Proposed Insured/ Patient (*please print*) ______________________________

Address of Proposed Insured/ Patient ______________________________

Social Security Number ____________________ Date of Birth ____________________

Driver's License Number ______________________________ State __________

I (the undersigned) authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or any other medically related facility, insurance support organization, insurance company, Medical Information Bureau (MIB), or other organization, institution or person that has any knowledge of or has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers") to disclose my entire medical record and any other protected health information, including but not limited to transaction records, employment records, financial reports, insurance, demographics, referral documents and records from other facilities concerning me to

MY AGENT: ______________________, ("My Agent") and to Carfagno Insurance Services, Inc and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome ("AIDS"), mental illness, chemical and/or alcohol dependency, 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 any of "My Providers" to disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that "My Agent", Carfagno Insurance Services, Inc, and the Insurance Companies listed below may:
(1) underwrite my application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations;
(2) obtain reinsurance; (3) administer claims and determine or fulfill responsibility for coverage and provisions of benefits;
(4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have or have applied for.

The Insurance Companies authorized are:
Aetna, AIG American General, AIS, American National, AVIVA, AXA Equitable Life, Banner Life, Beneficial Life, Carfagno Insurance Services, Inc, Equifax Services, Fidelity Life, First Colony, GE Financial Assurance, Genworth Life and Annuity, Guarantee Trust Life, The Hartford, Hooper Holmes, Indianapolis Life, InfoLink, ING Life, Insurance Designers, John Hancock, John Hancock USA, John Hancock of New York, Lafayette Life, Liberty Life, Lincoln National Life, Lincoln Benefit Life, Lloyds of London, Mass Mutual Life, Met Life, Met Life Investors, Midland National, Morton P. Greenberg, JD, CLU, Mutual of Omaha, National Life of Vermont, National Western Life, Nationwide, New England, New York Life, North American (NACOLAH), Old Mutual Life, OMG, Pacific Life, Petersen International Underwriters, Phoenix Life, Portamedic, Presidential Life, Principal, Protective Life, Protective Life and Annuity, Prudential, Reliastar Life, Reliastar Life of NY, Security Life of Denver, Standard Life of Oregon, Sun Life of Canada, Transamerica, Travelers Life and Annuity, Union Central, United of Omaha, UNUM/ Provident, US Financial, West Coast Life, Western Reserve Life, and
ENTITY NOT LISTED ABOVE: ____________________

This authorization shall remain in force for 24 months following the date of my signature, 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 "My Agent" or to Carfagno Insurance Services, Inc., 14500 Northsight Blvd., Suite 225, Scottsdale, AZ, 85260. I understand that a revocation is not effective to the extent that any of "My Providers" has relied on this Authorization or to the extent that an authorized party has a legal right to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of heath information.

Signature of Proposed Insured/ Patient or Personal Representative ______________________ Date __________

Description of Personal Representative's Authority or Relationship to Patient (*please print*) ______________________

Signature of Witness ______________________________ Date __________

A copy of this Authorization must be given to the Proposed Insured/ Patient