INFORMAL EVALUATOR

P.O. Box 419006 • St. Louis • Missouri • 63141 • 314-392-2841 • 800-645-2841 • FAX: 314-392-2842 • marketing@buiusa.com

Advisor's Name	Telephone Number	E-mail Address

Proposed Insured & Plan Information

FULL NAME:			OCCUPATION:	
PRODUCT:	FACE AMOUNT:	DATE OF BIRTH:	SEX:	STATE:
POLICY OWNER/BENEFICIARY:	PURPOSE OF INSURANCE (income replacement, estate liquidity, buy/sell, key-person, other):			

Underwriting Information

Completion of this form will allow BUI's in-house underwriters to research the market to identify the carrier(s) who will look most favorably upon your underwriting profile. Please complete the form as thoroughly as possible.

1. Have you ever applied for life insurance in the past? If "Yes", for most recent application please provide company name, rate class, face amount, and date. ☐ Yes ☐ No

_____

_____

2. Have you ever missed work for longer than 1 week due to a medical ailment? If "Yes", please provide details below. ☐ Yes ☐ No

_____

_____

3. Please indicate those that apply:

☐ **Cancer** (provide pathology report if available)

Type and location: _____

Stage, level, grade: _____

Date of Treatment: _____

Type of Treatment: ☐ Chemo ☐ Radiation ☐ Surgical

☐ **Diabetes**

Date of diagnosis: _____

Treatment (diet only, oral tablets, insulin): _____

Date & result of last Hemoglobin A1C test: _____

Complications, if any: _____

Treated for:

- ☐ Insulin reaction
- ☐ Diabetic coma
- ☐ Eye trouble
- ☐ Heart trouble
- ☐ High blood pressure
- ☐ Kidney trouble (albumin)
- ☐ Neuritis, neuralgia, or neuropathy
- ☐ Amputation
- ☐ Skin problems or infections
- ☐ Poor circulation or leg cramps

☐ **Heart Attack or Heart Disease**

Date of Surgery: _____

Number of vessels involved: _____

Heart Attack? ☐ Yes ☐ No

Date & result of last stress test: _____

☐ **Drug / Alcohol Use** (marijuana, narcotics, cocaine, etc.)

Type(s): _____

Frequency (Daily, 1/month, etc.): _____

Date of first use and last use: _____

Date(s) of any treatment for abuse or dependency: _____

Involved in AA or other support group: _____

☐ **Nicotine Use** (cigarettes, gum, patch, chew, cigars, vaping, etc.)

Types(s): _____

Frequency (Daily, 1/month, etc.): _____

Date of last use: _____

☐ **Aviation as a Pilot**

Certifications (PPL, CPL, IFR, CFI, etc.: _____

Type of aircraft(s): _____

Total flight hours as a pilot: _____

Flight hours as a pilot in the last 12 months: _____

Flight hours as a pilot in the next 12 months: _____

☐ **Non-US Citizen**

VISA Type: _____

Date of entry into the US: _____

Country of citizenship: _____

4. Your Height: _____' _____". Your Weight: _____ lbs. Weight loss in past 12 months? _____ lbs.

5. Please indicate those conditions for which you have ever received treatment (provide details below):

☐ Blood Pressure	☐ Asthma/Lung Disorder	☐ Crohn's Disease	☐ Rheumatoid or Psoriatic Arthritis
☐ Sleep Apnea	☐ Irregular Heart Beat	☐ Ulcerative Colitis	☐ Stroke or Transient Attack (TIA)
☐ Anxiety/Depression	☐ Hepatitis A, B, C	☐ High Cholesterol	☐ Other: _____

6. Is any future surgery or medical treatment planned or recommended? If "Yes", please provide details below. ☐ Yes ☐ No

7. Please list all medications (including over-the-counter) you have taken within the past 24 months and why:

8. Family History:	**Medical Condition** (Cancer, heart disease, diabetes, etc.)	**Age at Onset**	**Age if Living**	**Cause of Death**	**Age at Death**
Parent(s)					
Sibling(s)					

9. Have you ever traveled, or do you plan on traveling outside the U.S.? If "Yes", please provide details including destination(s), purpose, and length(s) of stay below. ☐ Yes ☐ No

10. Have you ever engaged in motor vehicle racing, SCUBA or sky diving, cliff or base jumping, mountain/ice/rock climbing, other similar activity, or plan to do so in the future? If "Yes", please provide details below. ☐ Yes ☐ No

11. Have you ever been charged with a felony, DUI, DWI, reckless driving or has your driver's license ever been suspended? If "Yes", please provide details below. ☐ Yes ☐ No

12. Have you ever declared bankruptcy? If "Yes", please provide details including chapter of bankruptcy, personal or business, cause, and date of discharge. ☐ Yes ☐ No

13. Is there any additional medical, financial, or activity history or intent that should be considered during the quoting process? If "Yes", please provide details below. ☐ Yes ☐ No

Authorization for Release of Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize BUI (the "Representative") and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided 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 information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the 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 with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to BUI, 11433 Olde Cabin Road, Third Floor, St. Louis, Missouri 63141, and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

Proposed Insured/Personal Representative Signature	Proposed Insured Name	Description of Personal Representative's Authority/Relationship to Insured	
Proposed Insured Social Security#	Proposed Insured Date of Birth	Signed and Dated On	At (City, State, Zip Code)

Agent/Witness Signature: X_____ **Print Agent/Witness Name: X**_____

Accordia Life, AIG, American Equity, American General Life Insurance Company, American National Insurance Companies, American United Life Ins. Co., Athene, Americo Life & Annuity, Banner Life Insurance Company, Brighthouse Life Insurance Company, Cincinnati Life, Companion Life Insurance Company, Equitable Life Insurance Company, Fidelity & Guarantee Life, Genworth Financial Family of Companies, General Re Life Corp, Global Atlantic, John Hancock, Legal and General America, Lincoln National Life, Mass Mutual, Mutual of Omaha Insurance Companies, Minnesota Life, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, OneAmerica, North American Co. for Life and Health, Pioneer Mutual Life Ins. Co., Oceanview Life & Annuity Company, Oxford Life Insurance Company, Pacific Life, Principal Life Insurance Co., Principal National Life Insurance Co., Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Sagicor, Savings Bank Life Ins. Co., Security Life of Denver Insurance Company, Security Mutual Insurance Company, Securian, Symetra, The Cincinnati Life Insurance Company, The State Life Ins. Co., TIAA-CREF Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, VOYA Financial, Inc., William Penn Life Insurance Company of New York, Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York.