

Policy Review Authorization

Date: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Policy Information: _____

Policy #: _____

Insured: _____ Date of Birth: _____

Owner: _____ SS#: _____

Please accept this letter as authorization for the below named individual/firm to be provided with any and all information regarding the above referenced policies, including current in-force ledgers.

Agent: _____/Specific Solutions

Address: 475 International Drive _____

City: Williamsville State: NY Zip Code: 14221

Fax: 716-632-6051

Authorization

I authorize _____/Specific Solutions, Inc. to obtain any and all information, including in-force ledgers.

X _____

Signature of Insured

Date

Print name of Insured

X _____

Signature of Policy Owner

Date

Print name of Insured

General Information

1.) What is the purpose of your current policy? _____

Mortgage Protection Family Protection Estate Tax Protection Income Replacement

2.) Please check mark any of the following conditions that you currently have or have had in the past. Please provide specific details and dates in the spaces provided. Also please note any other health concerns.

- | | |
|--|---|
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> COPD/Emphysema |
| <input type="checkbox"/> Cancer (Be Specific) | <input type="checkbox"/> Cardiac Bypass/Angioplasty/Stent Replacement |
| <input type="checkbox"/> Heart Attack/Angina | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> Heart Valve Surgery/Murmurs | <input type="checkbox"/> Hepatitis B or C |
| <input type="checkbox"/> Arrhythmias | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Lupus/Other Autoimmune Disorders |
| <input type="checkbox"/> Chrohn's Disease/Ulcerative Colitis | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Depression/Anxiety/Bipolar Disorder |
-
-
-
-

3.) Please list any medications that you are currently taking and the reason why.

4.) Do you use Tobacco? Yes__ No__

If yes, What type and how much?: _____

If no, # of years without tobacco use?: _____

5.) Height _____ Weight _____