

# 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

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## 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"/> Arrythmias                          | <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          |

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

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4.) Do you use Tobacco? Yes\_\_ No\_\_

If yes, What type and how much?: \_\_\_\_\_

If no, # of years without tobacco use?: \_\_\_\_\_

5.) Height \_\_\_\_\_ Weight \_\_\_\_\_