THE SPECIFIC SOLUTIONS GROUP

...the life, annuity, long term care & disability income problem solvers

SPECIFIC SOLUTIONS, INC. • CORPORATE SERVICES, LTD. • LONG & LONG AND ASSOC.
475 International Drive • Williamsville, New York 14221-5772
(716) 632-7777 • (800) 873-2345 • (716) 632-6051 Fax

Website
www.specificsolutions.com

email
agency@specificsolutions.com

PRELIMINARY INQUIRY

IF CARDIOVASCULAR, DIABETES OR CANCER HISTORY, PLEASE COMPLETE APPROPRIATE FORM ON REVERSE SIDE.

FULL NAME (Print) ☐ M ☐ F		PLANS OF INSURANCE	AMOUNT $ / DIS. INC. ONLY BEN. PER ELIM. PER
DATE & PLACE OF BIRTH	SOCIAL SECURITY NO.	HOW MUCH INSURANCE IN FORCE NOW? Life $ _____ Dis. Inc. $ _____ /Mo.	
RESIDENCE ADDRESS ☐		HEIGHT ____ Ft. ____ Inches WEIGHT _____ Lbs.	Have you ever used tobacco? ☐ YES ☐ NO If yes, what type _____ Date last used _____
PURPOSE OF INSURANCE ☐ Business ☐ Personal			
OCCUPATION & EXACT DUTIES _____ EMPLOYER _____ AVERAGE ANNUAL EARNINGS $_____			

FAMILY RECORD	IF LIVING		IF DECEASED	
	Ages	Health Problems (if any)	Ages	Cause of Death
FATHER				
MOTHER				
BROTHERS				
SISTERS				

Has proposed insured ever been rated or declined for insurance? ☐ Yes ☐ No

Is there any inquiry or application for coverage currently pending? ☐ Yes ☐ No

IF EITHER QUESTION ABOVE IS ANSWERED YES, COMPLETE THE FOLLOWING:

COMPANY	YEAR	AMOUNT	IN FORCE?	PREMIUM	RATING	REASON

	NAME AND ADDRESS	REASON	DATE
What physicians have you consulted during the past 10 years			
In what hospitals, clinics, or sanitariums have you been treated?			
Who is your personal physician? When did you last consult him?			
Physician first consulted for medical condition (s) this inquiry pertains to?			
Physician now giving treatment or medical supervision for above.			

IF CARDIOVASCULAR, DIABETES OR CANCER HISTORY, PLEASE COMPLETE APPROPRIATE FORM ON REVERSE SIDE.

AGENT'S NAME _____ AGENT'S PHONE NUMBER _____

AGENT'S ADDRESS _____

CARDIOVASCULAR, DIABETES AND CANCER QUESTIONNAIRE

Name of Proposed Insured:

Date of onset of chest pain, or diagnosis of cancer or diabetes:

Has treadmill (stress) electrocardiogram been performed: ☐ Yes ☐ No Date: _____

Results: _____

By whom : _____

CARDIOVASCULAR QUESTIONNAIRE

Please provide full details of all affirmative answers in the REMARKS section.

Have you ever had or been treated for:	Yes	No
a. Chest pain	☐	☐
b. Skipping of heart	☐	☐
c. Shortness of breath	☐	☐
d. High blood pressure	☐	☐
e. Angina pectoris (heart pain)	☐	☐
f. Myocardial infarction (heart attack)	☐	☐
Have you had or been advised to have:		
a. Cardiac Catheterization	☐	☐
b. Coronary Angioplasty	☐	☐
c. Coronary Artery Bypass Surgery	☐	☐
d. Heart Valve Replacement	☐	☐
Was hospital care required	☐	☐
Have you had more than one episode	☐	☐
Any recurrence of pain subsequent to initial diagnosis or surgery, if performed	☐	☐
Are you now, or have you been, on medication such as digitalis, peritrate nitroglycerin vasodilators blood pressure medicine, etc (List medication in REMARKS)	☐	☐
Do you carry a pill to be placed under the tongue for chest discomfort	☐	☐

DIABETES QUESTIONNAIRE

Please provide full details of all affirmative answers in the REMARKS section.

What treatment do you use:	Yes	No
Diet only	☐	☐
Insulin	☐	☐
Name_____ No. of Units_____ /day		
Oral Medication	☐	☐
Name_____ No. of Units_____ /day		
Do you regularly test your urine for sugar	☐	☐
Results (please check): Usually: Negative ☐ Trace ☐ More than trace ☐		
Last Test: Date _____ Result _____		
Have you had any blood sugar tests:	☐	☐
Date _____ Result _____		
Have you had glycohemoglobin testing performed	☐	☐
Date _____ Result _____		
Have you been treated for	☐	☐
Insulin reactions	☐	☐
Diabetic coma	☐	☐
Give dates, physician, and hospital in REMARKS.		
Have you ever had:		
a. Any eye trouble (retinopathy)	☐	☐
b. Heart trouble	☐	☐
c. High blood pressure	☐	☐
d. Kidney trouble (albuminuria, etc.)	☐	☐
e. Neuritis, neuralgia, or neuropathy	☐	☐
Give dates, physician, and hospital in REMARKS.		
Has weight changed in past year	☐	☐
Weight 1 year ago _____ lbs. Present weight _____ lbs.		

CANCER QUESTIONNAIRE

Please provide full details of all affirmative answers in the REMARKS section.

Have you ever had or been treated for:	Yes	No
a. Cancer	☐	☐
b. Hodgkins Disease/Lymphoma	☐	☐
c. Leukemia	☐	☐
Site of cancer:		
a. Breast	☐	☐
b. Colon, Stomach	☐	☐
c. Kidney, Bladder, Reproductive Organs	☐	☐
d. Liver	☐	☐
e. Lung	☐	☐
f. Brain	☐	☐
g. Bone	☐	☐
h. Lymph Nodes	☐	☐
i. Skin	☐	☐
j. Thyroid	☐	☐
k. Other _____		

Specify treatment rendered:	Yes	No
a. Surgery	☐	☐
Date Completed _____		
b. Radiation	☐	☐
Date Completed _____		
c. Chemotherapy	☐	☐
Date Completed _____		

Provide stage, level or grade, if known, at time of onset. List any other conditions requiring ongoing treatment or medication.

_____

_____

Any special testing; i.e., bone scans, CAT scans, or biopsies of additional tissue:

Dates: _____

Results: _____

REMARKS:

The statements and answers shown above are complete and true to the best of my knowledge and belief.

Signature of Proposed Insured _____ Date _____ 20 _____

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AUTHORIZATION FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

(THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE)

Name of Proposed Insured/Patient (please print) Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to any one (or all) of The Specific Solutions Group of companies ("The Company"), its agents, employees, insurance support organizations, insurers, reinsurers, and their representatives. This includes information concerning 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 (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco.

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by The Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction. I understand that my personal information, including my protected health information disclosed under this authorization, will be incorporated into and made a part of any life and/or disability insurance policy(s) issued in connection with the application(s) for insurance that I have submitted to the Company. I further understand that the policy(s) will be delivered to the policy owner, which may be my employer or other party. The information included and forming a part of such policy(s), including my protected health information, may be disclosed to the policy owner.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that The Company may; 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance offers; and 3) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for through The Company.

The following groups of persons employed or working for The Company may use my personal health information which is described above: employees of the underwriting, administration, and any other personnel of The Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with The Company.

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure.

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 at any time. The request for revocation must be in writing and sent to: The Specific Solutions Group, 475 International Dr., Williamsville, NY 14221. I understand that a revocation is not effective if The Company has relied on the protected health information disclosed to it. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, The Company may not be able to process my application for coverage, or if coverage has been issued, may not be able to make any such benefit payments. Upon receipt of your signed authorization, a copy will be provided to you. Any alteration of this form will not be accepted.

X

Signature of Proposed Insured/Patient or Personal Representative Date

If you are the personal representative of the proposed insured/patient, describe the scope of your authority to act on this individual's behalf (*parent, legal guardian, power of attorney, etc.*) on the line above.

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agency@SpecificSolutions.com

MEDICAL RELEASE OF INFORMATION
FOR PARAMEDS.COM / EMSI / SPECIFIC SOLUTIONS / EXAMONE

Form# MRI-541
Revised: April 2017

Patient Name _____

Medical Record # / SS# _____ Date of Birth _____

Home Phone # _____ Work # _____

Address _____

City _____ State _____ Zip _____

The undersigned hereby authorizes the use or disclosure of the above named individual's health information as described below:
The following individual or organization is authorized to make the disclosure:

Physician/Clinic Name _____

Address _____

City _____ State _____ Zip _____

Phone Number _____

The type and amount of information to be used or disclosed is as follows:

- ◯ 5 years back, complete records
- ◯ 10 years back, complete records
- ◯ All records, complete chart
- ◯ Specific information _____

I understand the information in my health record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Syndrome (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to: Parameds.com / EMSI / Specific Solutions or ExamOne. This information may be disclosed and used by the following organizations for the purpose of Life Insurance: Release to:

Parameds.com 120-10 Queens Boulevard Kew Gardens, NY 11415	Specific Solutions 475 International Drive Williamsville, NY 14221	Examination Management Services, Inc. 8300 Central Park Drive Waco, TX 76712	ExamOne 800 NW Chipman Road, Suite 5900 PO Box 2340 Lee's Summit, MO 64063

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event of condition, this authorization will expire 1 year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164-524. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by federal confidentially rules. If I have any questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____
(Date) Signature of Patient

_____ _____
(Witness) Signature of Patient, guardian, or authorized representative
If signed by patient's authorized representative

_____
Printed name of authorized representative Relationship

_____
Address and telephone number of authorized representative

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COMPANY AUTHORIZATION FORM

ALLIANZ LIFE OF NY
AMERICAN GENERAL LIFE INSURANCE CO
AMERICAN NATIONAL LIFE INSURANCE CO
AMERICAN NATIONAL LIFE INSURANCE CO OF NY
AMERITAS LIFE INSURANCE CORP
AMERITAS LIFE INSURANCE CORP OF NY
ATHENE LIFE INSURANCE CO
ATHENE LIFE INSURANCE CO OF NY
AXA EQUITABLE LIFE INSURANCE CO
BANNER LIFE INSURANCE CO
COLUMBIAN MUTUAL LIFE INSURANCE CO
COMPANION LIFE INSURANCE CO
FIRST SYMETRA LIFE INSURANCE CO OF NY
FIRST UNUM LIFE INSURANCE CO
GENWORTH LIFE INSURANCE CO
GENWORTH LIFE INSURANCE CO OF NY
JOHN HANCOCK LIFE INSURANCE CO
JOHN HANCOCK LIFE INSURANCE CO OF NY
LIBERTY LIFE ASSURANCE CO OF BOSTON
LIFE INSURANCE CO OF THE SOUTHWEST
LINCOLN LIFE AND ANNUITY CO OF NY
LINCOLN NATIONAL LIFE INSURANCE CO
MASSACHUSETTS MUTUAL LIFE INSURANCE CO
METLIFE
METROPOLITAN LIFE INSURANCE CO
MINNESOTA LIFE INSURANCE CO
MUTUAL OF OMAHA
NATIONAL LIFE INSURANCE CO
NATIONWIDE LIFE INSURANCE CO
NEW YORK LIFE INSURANCE CO
NORTH AMERICAN CO FOR LIFE AND HEALTH
PENN MUTUAL LIFE INSURANCE CO
PRINCIPAL LIFE INSURANCE CO
PRINCIPAL NATIONAL LIFE INSURANCE CO
PROTECTIVE LIFE AND ANNUITY INSURANCE CO
PROTECTIVE LIFE INSURANCE CO
PRUCO LIFE INSURANCE CO
PRUCO LIFE INSURANCE CO OF NJ
PRUDENTIAL INSURANCE CO OF AMERICA
RELIASTAR LIFE INSURANCE CO
RELIASTAR LIFE INSURANCE CO OF NY
SAVINGS BANK LIFE INSURANCE CO OF MA
SECURIAN LIFE INSURANCE CO
SECURITY MUTUAL LIFE INSURANCE CO OF NY
SYMETRA LIFE INSURANCE CO
THE STANDARD LIFE INSURANCE CO
THE STANDARD LIFE INSURANCE CO OF NY
TRANSAMERICA FINANCIAL LIFE INSURANCE CO
TRANSAMERICA LIFE INSURANCE CO
UNITED OF OMAHA LIFE INSURANCE CO
UNITED STATES LIFE INSURANCE CO
UNUM INSURANCE COMPANY OF AMERICA
VANTIS LIFE
VANTIS LIFE OF NY
VOYA
WILLIAM PENN LIFE INSURANCE CO OF NY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my health, to give any such information to The Specific Solutions Group or any one of the life insurance companies listed and its reinsuring companies.

A photographic copy of this authorization and acknowledgment shall be as valid as the original.

X

Date

Signature of Proposed Insured (*or Parent, if Proposed Insured is a Minor*)

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