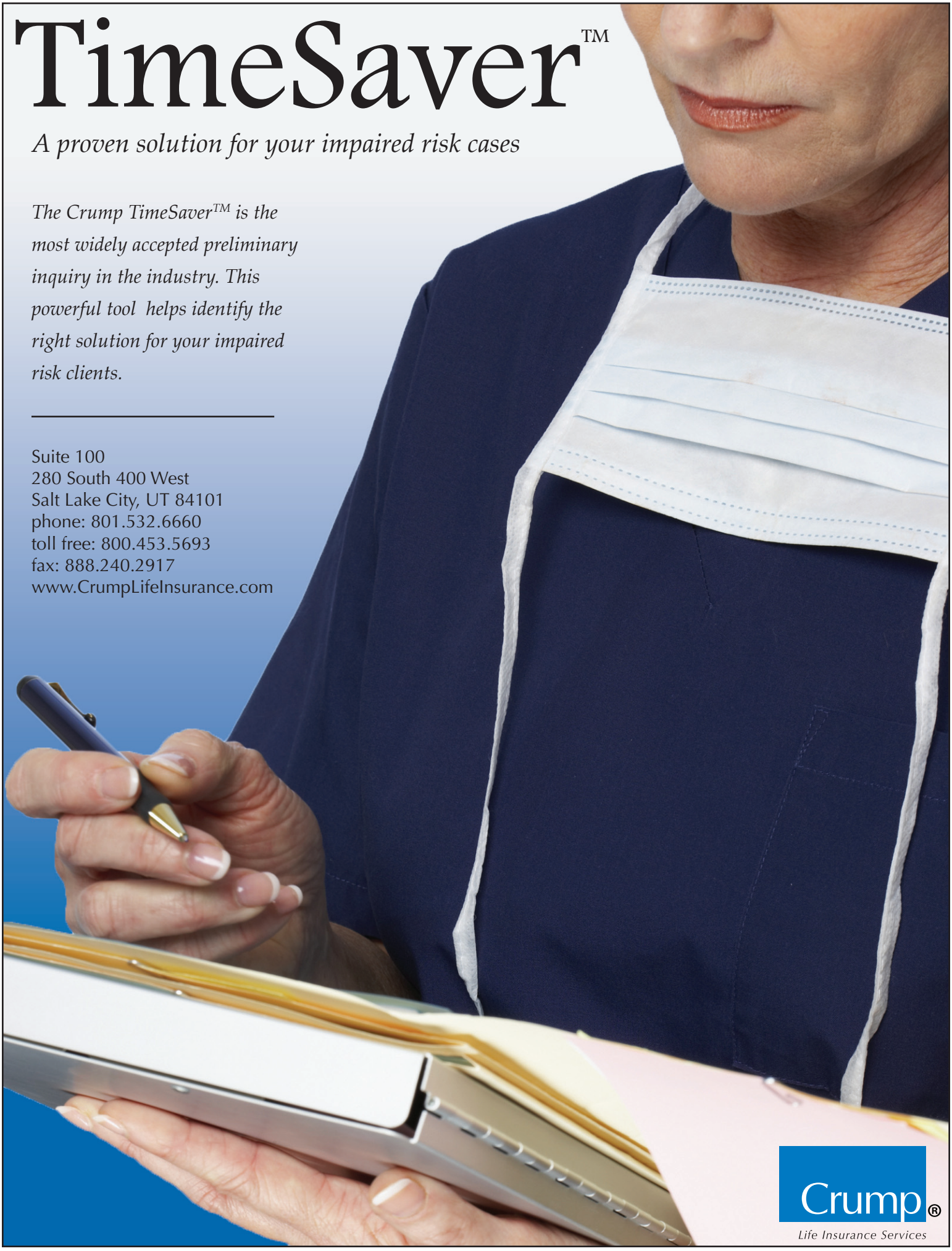
TimeSaver™

A proven solution for your impaired risk cases

The Crump TimeSaver™ is the most widely accepted preliminary inquiry in the industry. This powerful tool helps identify the right solution for your impaired risk clients.

Suite 100
280 South 400 West
Salt Lake City, UT 84101
phone: 801.532.6660
toll free: 800.453.5693
fax: 888.240.2917
www.CrumpLifeInsurance.com



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Preliminary Inquiry — Not an application for life insurance.
This TimeSaver™ form is used exclusively to gather specific information on a proposed insured's medical history and other factors that may impact underwriting and rating classification. This is not an application for insurance and in no way guarantees a specific underwriting class or binds any insurance coverage with any insurance carrier.

Crump Sales Manager _____ Phone _____

PERSONAL HISTORY (this section must be completed)

Name		☐ Male ☐ Female	Social Security Number		
Address		City		State	Zip
Date of Birth	Age	Height	Weight	Monthly Earned Income	Net Worth
Occupation					

PRODUCER INFORMATION (this section must be completed)

Name	Social Security Number	Crump Producer Number	
Address	City	State	Zip
Phone	Fax	Email Address	
Have you submitted this case previously? ☐ Yes ☐ No			

GOALS OF THE CASE (this section must be completed)

What is the ultimate goal of the case?	
What premium is needed to place the case?	
Are you in competition? ☐ Yes ☐ No	If in competition, with what companies?
Where has the case been shopped and list the outcome?	
Are there any carriers we shouldn't consider?	

Did you discuss this case with an Advanced Sales Associate? ☐ Yes ☐ No Did you discuss this case with an Underwriter? ☐ Yes ☐ No If yes, who? _____	Please check if applicable ☐ Business Planning ☐ Estate Planning ☐ Charitable Planning ☐ Other _____

Is your client interested in the following?
☐ Annuities ☐ Disability Insurance ☐ Long Term Care Insurance ☐ Life Settlements
(please complete the Disability questionnaire on the website and attach to this TimeSaver™)

All pages of the TimeSaver™ must be completed. Inquiry cannot be considered unless authorization is signed by Proposed Insured.

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Proposed Insured _____ Social Security Number _____

REQUESTED COVERAGE (this section must be completed)

Minimum Consideration: **$500,000 face amount for permanent products** **$750,000 face amount for term products**	☐ Universal Life ☐ Survivorship (please have other proposed insured submit TimeSaver™ as well) ☐ Variable Life ☐ Whole Life ☐ Term, Level Period _____
Face amount desired?	Will these premiums be financed? ☐ Yes ☐ No ☐ Possibly

If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? _____

Provide details on pending and in-force coverage:

Company	Policy/Application Date	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?

Life Settlements: Indicate any activity in the past five years

TOBACCO/NICOTINE USAGE (this section must be completed)

Have you ever smoked cigarettes:

☐ Yes ☐ No If yes, date of last usage:

Have you used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐ Yes ☐ No

If yes, provide types and last date of use:

MEDICAL HISTORY (this section must be completed)

	Doctor's name, address, phone	Date	Illness/Reason
Who is your primary care physician? When did you last consult him/her? Why?			
What other physicians have you consulted during the past five years? Why? (do not include insurance examinations)			
In what hospitals, clinics, or other health facilities have you ever been treated?			
List all medications, including over-the-counter drugs and vitamins			

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? If yes, provide details below. ☐ Yes ☐ No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

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Proposed Insured _____ Social Security Number _____

DRUG AND ALCOHOL USAGE QUESTIONNAIRE ☐ check here if this section is not applicable

Do you currently drink alcohol? ☐ Yes ☐ No		Do you ever drink substantially more than present? ☐ Yes ☐ No	
Date of last consumption: _____		If yes, when? _____	
Note amounts below:		Note amounts below:	
Type	**Amount per week**	**Type**	**Amount per week**
Beer		Beer	
Wine		Wine	
Liquor		Liquor	
Have you ever consulted a doctor or received treatment because of alcohol use? ☐ Yes ☐ No		Have you ever been arrested for driving under the influence of alcohol? ☐ Yes ☐ No If yes, provide date(s) _____	

Have you ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details _____

Type of drug(s) used _____ Date of last use _____

Doctor/facility name and address _____

CORONARY ☐ check here if this section is not applicable

Date of diagnosis or first chest pain	Number of diseased vessels	
Dates/details of treatment/surgery (examples: Angioplasty, Bypass)		
Date of last stress EKG	Results	By whom?
Any pain since treatment/surgery?		

CANCER ☐ check here if this section is not applicable

Exact name and location of cancer	Stage and grade
Who would have the pathology report	Date/details of treatment/surgery

DIABETES ☐ check here if this section is not applicable

Date of diagnosis	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details
Do you regularly test your blood glucose? ☐ Yes ☐ No	Results	Frequency
Latest result of glycohemoglobin (A1C) test _____ mg%	Date _____	
Have you been diagnosed with having protein and/or microalbumin in your urine? ☐ Yes ☐ No		

Have you ever had: Eye trouble ☐ Yes ☐ No Heart trouble ☐ Yes ☐ No High blood pressure ☐ Yes ☐ No
Have you ever had: Kidney trouble ☐ Yes ☐ No Neuritis/Neuralgia ☐ Yes ☐ No Insulin reactions ☐ Yes ☐ No

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Are you a private pilot? ☐ Yes ☐ No If yes, provide details.	How many total hours have you flown as Pilot in Command? _____	How many hours do you fly per year? _____	Do you have an IFR (instrument flight rating) ☐ Yes ☐ No

Do you participate in the following activities? (circle those that apply)

Scuba Diving Bungee Jumping Ultralight Flying Sky Diving
Mountain Climbing Hang Gliding Auto/Motorcycle Racing Other _____

Please refer to our website or contact your Sales Manager for additional questionnaires and information.

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AUTHORIZATION

INSURANCE CARRIERS

Allianz Life Insurance Company of New York
Allianz Life Insurance Company of North America
Allstate Life Insurance Company of New York
American General Life
American National Insurance Company
Assurity Life
Aviva Life and Annuity Company
Aviva Life and Annuity Company of NY
AXA-Equitable
Banner Life
Companion Life of NY
Fidelity Security
First MetLife Investors Insurance Company
First Symetra National Life Insurance Company of New York
Genworth Life and Annuity Insurance Company
Genworth Life Insurance Company
Genworth Life Insurance Company of NY
ING ReliaStar Life Insurance Company
ING ReliaStar Life Insurance of NY
ING Security Life of Denver
John Hancock (USA)
John Hancock Life Insurance Company of NY
Liberty Life Assurance
Liberty Life Insurance Company
Lincoln Benefit Life
Lincoln Financial
Lincoln Life & Annuity of NY
Lloyd's of London
MetLife Investors
Metropolitan Life Insurance Company
Minnesota Life*
Mutual of Omaha
National Life Insurance Company
Nationwide
North American Life & Health
Old Mutual Financial Life Insurance Company
Penn Mutual
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life
Protective Life & Annuity Insurance Company
Prudential Financial
Security Mutual Life
Sun Life Financial/Annuity
Sun Life Financial
Sun Life Insurance & Annuity of NY
Symetra Life Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
United of Omaha Life Insurance Company
United States Life Insurance of NY
West Coast Life
William Penn Insurance Company of NY

**Limitations apply; see your Sales Manager for questions.*

PREMIUM FINANCING ENTITIES

21st Services
Advanced Wealth Planning Group
American Viatical Services, LLC
Burgess Group
C2
Cambridge Financing Company (CFC)
Capital Management Strategies, Inc. (CMS)
Credit Suisse
Deutsche Bank
Enterprise Bank & Trust
Examination Management Services, Inc. (EMSI)
Fasano Associates, Inc.
First Boston LLC
First Choice Strategies
First Insurance Funding
Goldman Sachs
Heritage Labs International, LLC
Insurative US (IPF)
Isthmus Capital LLC (Concord)
Northern Trust
Premium Funding Group (PFG HyBRID)
Ridge Capital Partners, LLC
Sentinel Funding Group, LLC

_____
Print Name of Proposed Insured

_____
Proposed Insured's Signature (or that of Authorized Representative)

_____
Date

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AUTHORIZATION

This Authorization is HIPAA compliant.

Proposed Insured:_____

Date of Birth:_____ Social Security #: _____

Purpose:
The purpose of this HIPAA Authorization (the "Authorization") is to permit Crump Life Insurance Services, Inc. and its affiliates to obtain non-public personal information about me, the Insured named above, for the purposes of (1) to determine my eligibility for and obtaining insurance products and services from one or more of the insurance carrier or other entities; (2) to monitor, track, or verify my health or medical status and condition in connection with any life insurance policy under which my life is insured, including any conversions thereof or replacements therefore; and (3) to develop and use indices that do not personally identify individuals related to actual and anticipated longevity, mortality, life expectancies, and/or similar measures.

Information to be Released:
The term "Information" as used in this Authorization refers to the information to be released pursuant to this Authorization including but not limited to any non-public personal, financial, health information, records or data concerning my past, present or future mental, physical or behavioral health or condition ("Information"), to the extent permitted by law.

Specifically, Information includes all information, records or data relating to my: physical or mental history or condition; medical treatment, diagnosis, or prognosis, including medications prescribed to me; other insurance coverage(s); hazardous activities; general character and general reputation; finances; occupation; avocation, including any hazardous hobbies; driving records; aviation activities and other personal traits. The term Information does not include psychotherapy notes.

I understand that this Information may include results from blood, saliva, urine and other tests.

I further understand that this Information may, if applicable, include information regarding diagnosis, prognosis and treatment of: alcohol or drug abuse (including records protected under federal law, 42 CFR Part 2); serious communicable disease or infection, including sexually transmitted diseases; HIV infection, including medical test results.

Authorization:
I authorize any physician or other medical practitioner, any hospital, clinic, or other health-related facility, any medical testing laboratory, any insurer, any state motor vehicle department, my past or current employer(s), the Social Security Administration, and any other organization, institution or person (an Authorized HCP) that has Information about me to disclose any and all Information to Crump Life Insurance Services, Inc. and its agents and representatives. I also authorize my Agent, named below, to receive Information to assist in the purpose of this Authorization to the extent permitted by law.

I understand that Information disclosed to Crump Life Insurance Services, Inc. may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to Crump Life Insurance Services, Inc., it may no longer be subject to those laws and regulations. I understand that no Authorized HCP or covered entity may condition my treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.

A photocopy of this Authorization shall be as valid as the original. I will receive a copy of this Authorization.

I hereby further authorize Crump to deliver, disclose, give, provide, and release any and all Information in connection with the placement of a life insurance policy or related product to any insurance carrier or other entity for the purposes of health or medical information review or underwriting.

A partial list has been provided of such insurance carriers and other entities on page 4 of this TimeSaver™.

Right to Revoke Authorization:
This Authorization shall be effective for two (2) years after the date signed below. I acknowledge and understand that I may revoke this Authorization any time with respect to any Authorized HCP by notifying such Authorized HCP in writing of my revocation of this Authorization and delivering my revocation by mail or personal delivery at such address designated to me by such Authorized HCP, provided that, any revocation of this Authorization shall not apply to the extent that the Authorized HCP has taken action in reliance upon this Authorization prior receiving written notice of my revocation.

_____ _____
Proposed Insured's Signature (or that of Authorized Representative) Date

_____
Print Name of Proposed Insured

_____
If signed by Authorized Representative of Proposed Insured, describe authority, e.g., parent or guardian of minor child

_____
Print Name of Agent

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