

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.



underwriting

Limited to permanent and term cases with face amounts of \$1 million or greater.

#crumpUW





underwriting

The Crump TimeSaver™

The Crump TimeSaver™ (our informal inquiry) helps to identify potential solutions for your impaired risk clients by expediting the research of multiple carriers and determining which are more likely underwrite your clients to obtain a competitive offer.

GOALS

The goals section of the TimeSaver asks for imperative information that will help your Underwriter and sales team narrow down which carriers will be the best candidates for your clients. By knowing the premium tolerance, product information, and if the case was previously sent to carriers, we can focus on how to specifically negotiate with each carrier – helping to get you the offer needed to complete a sale.

PERSONAL HISTORY

The TimeSaver allows you to collect details that would not necessarily be addressed in medical records. Hazardous avocations, foreign travel, and driving history are important factors often overlooked in the informal underwriting process. Since these factors have a direct impact on the underwriting rate class, providing this information at the start of the process allows your Underwriter to address these issues head on, eliminating surprises and delays later in the underwriting process.

MEDICAL INFORMATION

Our job is to tell your client's story to the carrier. The TimeSaver can be instrumental in collecting the details of your client's medical history that helps our underwriters tell the story. Contact information for doctors, dates of treatments, medications, and build are pertinent aspects of any case. By you fully completing all medical sections of the TimeSaver – especially providing information on the more complex medical issues such as cancer, diabetes, or cardiac disease – valuable insight is gained to help determine what medical records should be ordered upfront, reducing the overall time it takes to complete the file.

While an offer is never guaranteed until the formal process is finalized, with a fully completed TimeSaver, the most accurate facts can present each case in a more favorable light.

CREDITS

The purpose of this section is to help your Underwriter best position your file with our carriers by highlighting any additional positive aspects of your medical or social history. Several of our carriers have crediting programs that can improve a proposed insured's underwriting assessment by one or more classes.

The TimeSaver is limited to permanent and term cases with face amounts of \$1 million or greater.

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 Regional Director _____

Phone _____

PERSONAL HISTORY (this section must be completed)

Name		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number	
Address		City		State	Zip
Date of Birth	Age	Height	Weight	Monthly Earned Income	Net Worth
Occupation					
Is the client a Foreign National? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list country of citizenship			
Has the client traveled outside the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, list the countries and dates visited			
Green Card? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Type of Visa					

Please complete the Foreign Travel Questionnaire

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check if applicable <input type="checkbox"/> Business Planning <input type="checkbox"/> Estate Planning <input type="checkbox"/> Charitable Planning <input type="checkbox"/> Other _____
Did you discuss this case with an Underwriter? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who? _____	
Is your client interested in the following? <input type="checkbox"/> Annuities <input type="checkbox"/> Disability Insurance <input type="checkbox"/> Traditional Long Term Care Insurance <input type="checkbox"/> LTC Hybrid Product (please complete the Disability questionnaire on the website and attach to this TimeSaver™)	

Proposed Insured _____

REQUESTED COVERAGE (this section must be completed)

Minimum Consideration: \$1 million face amount for permanent and term products	<input type="checkbox"/> Universal Life <input type="checkbox"/> Survivorship (please have other proposed insured submit TimeSaver [™] as well) <input type="checkbox"/> Variable Life <input type="checkbox"/> Whole Life <input type="checkbox"/> LTC Rider <input type="checkbox"/> Term, Level Period _____
Face amount desired?	Will these premiums be financed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Possibly
If you are replacing coverage, will there be any 1035 money with this replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what amount will be carried over? _____	
Was a recommendation made to the proposed insured to: Use distributions from an IRA or qualified plan to purchase this insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Hold this insurance coverage in a qualified plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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)

Has your client ever smoked cigarettes: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date of last usage: _____
Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, provide types and last date of use: _____

MARIJUANA USAGE (this section must be completed)

Does your client use marijuana <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the following:
Purpose <input type="checkbox"/> Recreational/Social <input type="checkbox"/> Medicinal Frequency _____ times per <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/> Year
Delivery Method <input type="checkbox"/> Ingested <input type="checkbox"/> Vaporized <input type="checkbox"/> Inhaled Date Last Used _____

MEDICAL HISTORY (this section must be completed)

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

Proposed Insured _____

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

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

Does your client currently drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your client ever drink substantially more than present? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type(s) of Alcohol _____	If yes, when? _____
Date of last consumption _____	Has your client ever consulted a doctor or received treatment because of alcohol use?
How much per week _____	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details _____
Has your client ever used illegal drugs or sought treatment because of drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details _____	
Type of drug(s) used _____	Date of last use _____

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 <input type="checkbox"/> Diet only <input type="checkbox"/> Oral medication <input type="checkbox"/> Insulin	Details
Does your client regularly test his/her blood glucose? <input type="checkbox"/> Yes <input type="checkbox"/> No	Results	Frequency
Latest result of glycohemoglobin (A1C) test _____ mg% Date _____		
Has your client been diagnosed with having protein and/or microalbumin in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have your client ever had:	Eye trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Have your client ever had:	Kidney trouble <input type="checkbox"/> Yes <input type="checkbox"/> No	Neuritis/Neuralgia <input type="checkbox"/> Yes <input type="checkbox"/> No
		High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No
		Insulin reactions <input type="checkbox"/> Yes <input type="checkbox"/> No

HAZARDOUS ACTIVITIES check here if this section is not applicable

Is your client a private pilot? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide details.	How many total hours has your client flown as Pilot in Command? _____	How many hours does your client fly per year? _____	Does your client have an IFR (instrument flight rating) <input type="checkbox"/> Yes <input type="checkbox"/> No
Does your client participate in the following activities? (check those that apply)			
<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Bungee Jumping	<input type="checkbox"/> Ultralight Flying	<input type="checkbox"/> Sky Diving
<input type="checkbox"/> Mountain Climbing	<input type="checkbox"/> Hang Gliding	<input type="checkbox"/> Auto/Motorcycle Racing	<input type="checkbox"/> Other _____

DRIVING HISTORY check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?
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Please refer to our website or contact your Account Manager for additional questionnaires and information.

All pages of the TimeSaverTM must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.

Proposed Insured _____

UNDERWRITING CREDITS

Completing the information below can help us secure the best offer for your client as many carriers can use various crediting options to improve offers.

Complete physical exam by a physician within the past year	Date of Testing _____	Doctor Contact Information _____
Executive physical (Mayo, Cooper Clinic, Cleveland Clinic) within the past year	Date of Testing _____	Doctor Contact Information _____
Preventative wellness studies within the past two years with normal results	Date of Testing _____	Doctor Contact Information _____
<input type="checkbox"/> Digital rectal exam	_____	_____
<input type="checkbox"/> PSA testing	_____	_____
<input type="checkbox"/> Physician skin exam	_____	_____
<input type="checkbox"/> Physician testicular exam	_____	_____
<input type="checkbox"/> Colonoscopy	_____	_____
<input type="checkbox"/> Occult blood in stool testing (stool cards)	_____	_____
<input type="checkbox"/> Bone density test	_____	_____
<input type="checkbox"/> Mammogram	_____	_____
<input type="checkbox"/> Pap smear	_____	_____
<input type="checkbox"/> Physician breast exam	_____	_____

Exercise (list type of exercise, how many times per week and length of each session)

Cardiac testing within the past two years with normal results	Date of Testing _____	Doctor Contact Information _____
<input type="checkbox"/> Resting EKG	_____	_____
<input type="checkbox"/> Treadmill stress test	_____	_____
<input type="checkbox"/> Nuclear stress test	_____	_____
<input type="checkbox"/> Echocardiogram	_____	_____
<input type="checkbox"/> Catheterization or angiogram	_____	_____
<input type="checkbox"/> Coronary Calcium Testing (EBCT) with a zero score	_____	_____

Other testing within the past two years with normal results	Date of Testing _____	Doctor Contact Information _____
<input type="checkbox"/> Chest CT	_____	_____
<input type="checkbox"/> Abdominal CT	_____	_____
<input type="checkbox"/> Normal CBC (Complete Blood Count)	_____	_____
<input type="checkbox"/> Normal Pulmonary Function Testing/Spirometry	_____	_____

Older Age (70+)

Driving (distance traveled per week in miles) _____

Social clubs/groups/volunteer work _____

Hobbies _____

Travel in the past year _____

Does the client handle their own financial affairs/investments? _____

Does the client work full time, part time, or in consulting? _____

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

All pages of the TimeSaver[™] must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.



Proposed Insured _____ Social Security Number _____

HIPAA AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The undersigned insured(s) (hereafter referred to as "I", "me" or "my"), authorizes the use and disclosure of my personal health and medical information protected by state and federal law including the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as follows:

Description and Purpose of Disclosure: This authorization shall apply to any and all of my personal health and medical information, including medical records in their entirety which may contain mental health records (excluding psychotherapy notes, as defined by HIPAA) and restricted records, life expectancy reports, prescription drug records, HIV-related information, use of alcohol or controlled or prohibited substances, and employment records, whether or not personally or individually identifiable (collectively referred to as my "PHI"). This authorization and all uses and disclosures of my PHI made under this authorization are for the purposes of allowing Crump Life Insurance Services Inc. and any affiliated companies (hereinafter collectively "Crump") and any Authorized Recipient (as defined below) to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or (2) market Insurance Products and Services to me.

"Insurance Products and Services" means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also include long term care or other types of health insurance.

Classes of Persons Authorized to Disclose My PHI: I authorize any health care provider, including any doctor, hospital or medically-related facility, nurse, pharmacy, physician, practitioner, or practitioner practice group (each an "Authorized HCP"), and any insurance company, HMO/PPO or similar organization, employer or, except as may be limited by state law, any other organization, institution or person that has my PHI to disclose to Crump or any Authorized Recipient, any such records or information as provided under this authorization.

Classes of Persons Authorized to Receive My PHI: PHI received by Crump may be disclosed under this authorization to any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described (each an "Authorized Recipient").

Further Disclosure Authorization: I authorize each Authorized Recipient to further disclose my PHI as necessary to carry out the purposes under this authorization. I understand and acknowledge that PHI that is redisclosed by the Authorized Recipient may no longer be protected by law. I further acknowledge that some state and federal laws prohibit the further disclosure of information regarding the diagnosis, prognosis and treatment of drug or alcohol abuse, communicable diseases or infection including sexually-transmitted diseases or HIV without specific written consent. I hereby authorize Crump and each Authorized Recipient to further disclose the foregoing information to the extent such disclosure is necessary in order to carry out the purposes under this authorization.

Expiration of Authorization: This authorization shall remain valid for two (2) years after the date signed below.

Right to Revoke: I understand that I may revoke this authorization at any time by sending a written request for revocation to Crump or to any Authorized HCP at such address designated to me. Any revocation of this authorization shall not apply to the extent that any person has taken action in reliance upon this authorization prior to receiving written notice of my revocation.

This authorization complies with the provisions of the HIPAA Privacy Rule governing authorizations (45 C.F.R. Sec. 164.508). I understand that this authorization is a requirement for the underwriting, sale or settling of Insurance Products and Services and Crump may condition enrollment, eligibility, benefits, sale or settling of Insurance Products and Services on whether I sign this authorization.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. I certify that I am executing and delivering this authorization freely and voluntarily as of the date written below. I further certify that I have received and retained a copy of this signed authorization for future reference.

Signature of Insured/Proposed Insured

Date

Signature of Authorized Representative

Date

Relationship/Authority to Represent



Proposed Insured _____ Social Security Number _____

AUTHORIZATION FOR USE AND DISCLOSURE OF NONPUBLIC PERSONAL INFORMATION (NPI)

I, the Policy Owner/Proposed Policy Owner, authorize Crump Life Insurance Services Inc. or any affiliated company (hereinafter collectively "Crump") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient, as such terms are defined below. This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Tellus and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; and/or; (2) market Insurance Products and Services to me.

I, the Insured/Proposed Insured (if different than the Policy Owner/Proposed Policy Owner), authorize Crump Life Insurance Services Inc. or any affiliated company (hereinafter collectively "Crump") to use and disclose any and all Nonpublic Personal Information (NPI) about me to any Authorized Recipient (as such terms are defined below). This authorization and all uses and disclosures of my NPI made under this authorization are for the purposes of allowing Tellus and any Authorized Recipient to: (1) determine my eligibility for Insurance Products and Services, as defined below; (2) market Insurance Products and Services to me; and/or (3) underwrite my health and/or life expectancy in connection with Insurance Products and Services.

"Nonpublic Personal Information" means information, including, without limitation, nonpublic personal, financial, health and medical information about the Policy Owner and Insured (if different than the Policy Owner) and the Policy Owner/Insured's identity as an owner/insured under a Life Insurance Policy that is obtained, whether from the Policy Owner/Insured, any of the Policy Owner's/Insured's agents or representatives, any insurance company, health care or medical provider, professional or facility or any other source.

"Authorized Recipient" includes any affiliates, subsidiaries, corporate parents, agents, independent contractors, insurance carriers, authorized representatives, premium finance entities, settlement providers, policy buyers or potential policy buyers, life expectancy underwriters and the officers, directors, employees, agents, and other representatives of each and to any other person or entity for the purposes herein described.

"Insurance Products and Services" means, for example, life insurance, disability insurance, as well as premium financing and other similar types of products and services. Insurance Products and Services also include long term care or other types of health insurance.

The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each agree and consent that this authorization shall be effective from the date hereof until the earlier of (a) the date that is two (2) years after the date hereof, or (b) an earlier date as may be required by applicable law or regulation. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) have the right to revoke this authorization, at any time, by providing written notification to Crump.

A copy or facsimile of this authorization shall be as valid as the original. This authorization may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which counterparts, taken together, shall constitute but one and the same instrument. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) each certify that he or she is executing and delivering this authorization freely and voluntarily as of the date written below. The Policy Owner and Insured/Proposed Policy Owner and Insured (if different than the Policy Owner) further certify that the authorization is written in plain language and acknowledge that each has received and retained a copy of this signed authorization for future reference.

Signature of Insured/Proposed Insured

Printed Name

Date

Proposed Insured _____

AUTHORIZED RECIPIENTS

INSURANCE CARRIERS

Allianz Life Insurance Company of North America
American General Life Insurance Company
American National Insurance Company
American National Life Insurance Company of NY
Ameritas Life Insurance Corp.
Ameritas Life Insurance Corp. of NY
Assurity Life Insurance Company
Assurity Life Insurance Company of New York
AXA Equitable Life Insurance Company
Banner Life Insurance Company
Brighthouse Life Insurance Company
Brighthouse Life Insurance Company of New York
Columbian Life Insurance Company
Columbian Mutual Life Insurance Company
Companion Life Insurance Company
Fidelity Security Life Insurance Company
Fidelity Security Life Insurance Company of New York
First Symetra National Life Insurance Company of New York
Foresters
Forethought Life Insurance Company
Gerber Life Insurance Company
Global Atlantic Financial Group
Guardian Life Insurance Company
Illinois Mutual Life Insurance Company
John Hancock Life Insurance Company (USA)
John Hancock Life Insurance Company of NY
Life Insurance Company of the Southwest*
LifeSecure Insurance Company
Lincoln Life Insurance & Annuity Co. of NY
Lincoln National Life Insurance Company
Lloyd's of London
Mass Mutual*

Minnesota Life Insurance Company
Mutual of Omaha
National Guardian Life Insurance Company
National Life Insurance Company*
Nationwide Life Insurance Company
New York Life*
North American Co. for Life & Health
Pacific Life & Annuity Company*
Pacific Life*
Pan American Life*
Penn Insurance & Annuity Company
Penn Mutual Life Insurance Company
Principal Life Insurance Company
Principal National Life Insurance Company
Protective Life & Annuity Insurance Company
Protective Life Insurance Company
Prudential Life Insurance Company
ReliaStar Life Insurance Company of NY
Securian Life Insurance Company
Security Life of Denver
Security Mutual Life Insurance Company of NY
State Life Insurance Company
Symetra Life Insurance Company
The Standard
The Standard Life Insurance Company of New York
The United States Life Insurance Company in the City of New York
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
United of Omaha Life Insurance Company
Voya Financial
Western-Southern Life Assurance Company
William Penn Life Insurance Company of NY

**Limitations apply; contact your Regional Director for details.*