

Impaired Risk
solution center



TimeSaver™

A proven solution for your impaired risk cases

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

280 South 400 West, Suite 100
Salt Lake City, UT 84101
phone: 801.532.6660
toll free: 800.453.5693
fax: 801.530.7270

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.

BISYS Sales Manager: _____ Phone: _____

Personal History - (this section must be completed)

Name _____ Male Female Soc. Sec. # _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ Age _____ Height _____ Weight _____ Monthly Earned Income \$ _____
 Occupation _____

Tobacco/Nicotine Usage

1. Have you ever smoked cigarettes: Y / N if yes, date of last usage: ____ - ____ - ____
2. Have you used other tobacco or nicotine containing products: Y / N (examples: cigars, pipe, snuff, nicotine gum or patch)
 If yes, provide types and last date of use:

Agent Information - (this section must be completed)

Name Mark L. Roden Soc. Sec. # 447664321 BISYS Agent ID _____ Phone No. 972-898-8063
 Address 6021 Morriss Rd #113 City Flower State TX Zip 75028 Fax No. 866-402-3483
 Email Address mroden@mc2health.com

Requested Plan of Insurance - (this section must be completed)

Minimum Consideration: \$500,000 face amount and/or minimum premium of \$2,500

Universal Life Variable Life Whole Life Term, Level Period _____ Survivorship* Disability Income, Monthly Benefit Amount _____
 Face amount desired: _____ Premium amount desired: _____ Annually Monthly
 Will these premiums be financed? Y / N If yes, complete the Addendum to the TimeSaver™ Preliminary Inquiry for Premium Financing Programs HIPAA Autho.
 If you are replacing coverage, will there be any 1035 money with this replacement? Y / N If yes, what amount will be carried over? \$ _____
 What is the purpose of the insurance? _____

*Please have other proposed insured submit TimeSaver as well.

Provide details on pending and in-force coverage:

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

Medical History - (this section must be completed)

1. Who is your primary care physician? When did you last consult him/her? Why?	Doctor's name, address, and phone number	Date	Illness
2. What other physicians have you consulted during the past five years? Why? (Do not include insurance examinations.)			

Proposed Insured: _____

Soc. Sec. #: _____

Medical History (continued) - (this section must be completed)

3. In what hospitals, clinics, or other health facilities have you ever been treated?	Date	Illness
4. Please list all current medications.		

Family History - (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease or cancer? Y / N

If yes, please provide the following details:

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

Do you currently drink alcohol? Y / N

Date of last consumption: _____

Note amount below.

Did you ever drink substantially more than present? Y / N

If yes, when? _____

Note amount 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 your alcohol use? Y / N

Have you ever been arrested for driving under the influence of alcohol? Y / N

If yes, provide date(s): _____

Have you ever used illegal drugs or sought treatment because of drug use? Y / N

If yes, provide details:

Types of drug(s) used: _____

Date of last use: _____

Doctor/Facility name and address: _____

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

Proposed Insured: _____

Soc. Sec. #: _____

Coronary - check here if this section is not applicable

1. Date of diagnosis or first chest pain: _____ - _____ - _____
2. Number of diseased vessels: _____
3. Dates/details of treatment/surgery (examples: Angioplasty, Bypass)

4. Date of last stress EKG: _____ - _____ - _____
 Results: _____
 By whom? _____
5. Any pain since treatment/surgery? _____

Cancer - check here if this section is not applicable

1. Exact name and location of cancer: _____

2. Stage and grade: _____

3. Who would have the pathology report? _____

4. Dates/details of treatment/surgery: _____

Diabetes - check here if this section is not applicable

1. Date of diagnosis: _____ - _____ - _____
2. Treatment: (circle one) Diet Only Oral Medication Insulin
 Details: _____
3. Do you regularly test your blood glucose? Y / N
 Results: _____ Frequency: _____
4. Latest result of glycohemoglobin (A1C) test: _____ mg%
 Date: _____ - _____ - _____
5. Have you been diagnosed with having protein and/or microalbumin in your urine? Y / N
6. Have you EVER had:

a. any eye trouble?	Y / N	d. kidney trouble?	Y / N
b. heart trouble?	Y / N	e. neuritis/neuralgia?	Y / N
c. high blood pressure?	Y / N	f. insulin reactions?	Y / N

Hazardous Activities - check here if this section is not applicable

Are you a private pilot? Y / N If yes, provide details below.
 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)? Y / N

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 _____

AUTHORIZATION

This Authorization is HIPAA compliant.

Proposed Insured: _____

Date of Birth: _____ Social Security #: _____

Purpose:

The purpose of this Authorization is to permit BISYS Insurance Services to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers or other institutions ("the Companies") listed below. Information that may be released to and disclosed by BISYS Insurance Services and the Companies listed below pursuant to this Authorization shall include any and all Information, to the extent permitted by applicable law.

Information to be Released:

The information to be released pursuant to this Authorization includes any personal 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.

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 that has Information about me to release such Information to BISYS Insurance Services, and its authorized representatives.

I specifically authorize the Companies listed on the next page to receive Information from and to release Information to BISYS Insurance Services. I also specifically authorize BISYS Insurance Services and the Companies listed on the next page to release Information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB) to release Information directly to any Company listed on the next page, upon such insurer's request, provided the insurer is a member of MIB. *

I understand that Information disclosed to BISYS Insurance Services may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to BISYS Insurance Services, it may no longer be subject to those laws and regulations.

I also authorize my Agent, named below, to receive Information and I authorize BISYS Insurance Services to disclose such Information to my Agent as necessary, to assist in the purpose of this Authorization the extent permitted by law.

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

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to BISYS Insurance Services at either 4250 Crums Mill Road, Harrisburg, PA 17112, or Suite 100, 280 South 400 West, Salt Lake City, UT 84101. Any action taken in reliance on this authorization prior to the notice of the revocation shall be valid.

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

*MIB is a nonprofit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with Information in its file. Member life insurance companies and their reinsurers may make brief reports of certain medical and non-medical information to MIB regarding any person for whom coverage is sought. If you contact MIB, it will disclose information it has about you in its file. If you feel the information in MIB's file is not correct, you can ask it to correct the information as provided in the Federal Fair Credit Reporting Act. You can write to MIB, Inc., Post Office Box 105, Essex Station, Boston, MA 02112 or call 1 (617) 426-3660.

Notice of Information Practices

Investigative Consumer Report

In addition to requesting a report from MIB, as a part of our underwriting process we or one of the insurance companies listed below may request an investigative consumer information report to confirm and supplement the information about your general health, employment and occupation, finances, smoking habits, and hazardous activities. Such a report may also cover your mode of living, except as may be related directly or indirectly to your sexual orientation, but including alcohol and drug use, general reputation, and driving record. Some of this information may be obtained through personal interviews with you or your family, friends, associates, or others with whom you are acquainted. If a consumer information report is requested, you may request to be personally interviewed if you can be contacted during normal business hours. An interview is normally conducted, but you are entitled to make a specific request.

We keep such information reports confidential and use them only to evaluate and underwrite your application.

You have a right under the Fair Credit Reporting Act to make a written request to inspect and obtain a copy of a consumer information report. If we request a report and the report has an adverse effect on your insurability, we will notify you in writing and give you the name and address of the reporting company.

Disclosure of Information

We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

We may disclose personal information about you without prior authorization under certain circumstances. For example, we may disclose Information about you to persons or organizations to allow such persons or organizations to perform a business, professional, or insurance function for us, or an insurance support organization, or to provide information to determine eligibility for insurance benefits or detect fraud, misrepresentation, or material non-disclosure. We may give information to accounting firms performing audits, governmental agencies reviewing our practices, or attorneys hired to protect our legal interest.

Information may be disclosed to reinsurance companies or another insurance company to which you have applied for coverage or benefits. Information may be furnished your agents to aid them in providing adequate service to you. Other disclosures may be made as permitted or required by law.

We may also disclose information to medical professionals where required by law for the purpose of informing you of a medical problem of which the you may not be aware or to persons or organizations for the purpose of conducting research including actuarial, marketing, and underwriting studies. This may include various insurance industry groups that conduct studies about risk experience or medical backgrounds of insured lives.

No medical record information or personal information relating to your character, personal habits, mode of living, or general reputation will be released to anyone who receives personal information for purposes of marketing a product or service.

You Can View and Correct Your Information

Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) Also, if the law allows us to do so, we may decide to disclose what we know about your health only through your health care provider. If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside BISYS Insurance Services.

If you want to know more about our privacy policy, please contact us at BISYS Insurance Services, Compliance Department, 4250 Crums Mill Road, Harrisburg, PA 17112.

Proposed Insured Initials: _____ **Date:** _____

Print Name: _____ **Soc. Sec. #** _____

Acacia Mutual	Continental Assurance Company	Indianapolis Life Insurance Company	Old Line Life	State Life
American General Life	Empire General Life	Jefferson Pilot Life Insurance	Old Republic Life	Sun Life Financial
American General Life of NY	EMSI	John Hancock Life Insurance Company	Phoenix	Travelers Insurance
AIG Life	Equitable Life of Iowa	Keyport Life Insurance Company	Physicians Mutual Life	UNUM Insurance
AIG Life of NY	Fidelity Security	Lincoln Benefit Life	Protective Life	United of Omaha
Allianz Life Insurance Company	F&G	Lincoln Life	Presidential Life Insurance Company	Unum Provident Corporation
American Mayflower	First Colony	Lincoln Life of NY	Principal Life Insurance Company	US Financial
American National Insurance Company	First Penn-Pacific	Lloyd's of London	Provident Life & Accident	US Life Insurance Co. in the City of NY
American Life Insurance Company of NY	First UNUM	Massachusetts Mutual Life	Provident Mutual	Valley Forge Life
Assurity Life	GE Capital Assurance	Manulife USA	Prudential Insurance	West Coast Life
Bankers Life of NY	GE Capital Assurance of NY	Manulife USA of NY	ReliaStar Life Insurance	William Penn
Banner Life	GE Financial Assurance	Metropolitan Life Insurance Company	ReliaStar Life Insurance of NY	Zurich Life
BISYS Insurance Services	GE Life & Annuity/LOV	MONY	Security Connecticut	Zurich Life Insurance Company of NY
Business Mens Assurance Co. of America	General American Life Insurance Co.	Mutual of Omaha	Security Life of Denver	
Canada Life Assurance	Gerber Life Insurance Company	Nationwide	Security Mutual Life	
Canada Life of NY	Guarantee Trust Life	New York Life	Security Mutual Life of NY	
CNA	Hartford Life Insurance	North American Life & Health	Southland Life	
Companion Life of NY	Illinois Mutual	North American Life & Health of NY	Standard	



Addendum to the TimeSaver™ Preliminary Inquiry for Premium Financing Programs (HIPAA Authorization)

Proposed Insured: _____

Date of Birth: _____ Social Security #: _____

This Addendum to the TimeSaver™ Preliminary Inquiry (the "Addendum") is made to add the following Authorization to Obtain and Release Information as part of the TimeSaver™ Preliminary Inquiry dated _____.

Purpose:

The purpose of this Addendum is to permit BISYS Insurance Services to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for and obtaining insurance products and services from one or more of the insurers listed on the TimeSaver™ Preliminary Inquiry or other entities through Premium Financing programs and life expectancy providers listed below. Information that may be released to and disclosed by BISYS Insurance Services and the Premium Financing programs and life expectancy providers listed below pursuant to this Addendum shall include any and all Information, to the extent permitted by applicable law.

Information to be Released:

The information to be released pursuant to this Addendum includes any personal 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.

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 that has Information about me to release such Information to BISYS Insurance Services, and its authorized representatives.

I specifically authorize the Premium Financing programs and life expectancy providers listed below to receive Information from and to release Information to BISYS Insurance Services. I also specifically authorize BISYS Insurance Services and the Premium Financing programs and life expectancy providers listed below to release Information about me to their reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them.

I understand that Information disclosed to BISYS Insurance Services may have been subject to state and federal privacy laws and regulations. Once Information is disclosed to BISYS Insurance Services, it may no longer be subject to those laws and regulations.

I also authorize my Agent, named below, to receive Information and I authorize BISYS Insurance Services to disclose such Information to my Agent as necessary, to assist in the purpose of this Authorization to the extent permitted by law.

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

This Authorization shall be effective for two (2) years after the date signed below, unless revoked by me in writing and written notice of the revocation is provided to BISYS Insurance Services at either 4250 Crums Mill Road, Harrisburg, PA 17112, or Suite 100, 280 South 400 West, Salt Lake City, UT 84101. Any action taken in reliance on this authorization prior to the notice of revocation shall be valid.

American Viatical Services, LLC, The August Group, Banyan Life Financial, Bedrock Funding LLC, CMS, First Coventry, EMSI, Fasano Associates, Inc., Finance for Life, Finestone Strategy Partners, Helix Capital Funding LLC, ICMG, MCC/Sierra, Park Venture Advisors, Premium Life, LLC, Rangetree, SBH Programs, LLC, 21st Services, and XE-R, LLC.

Print Proposed Insured Name: _____ **Date:** _____

Signature: _____

Print Proposed Insured Name: _____ **Date:** _____

Signature: _____

Print Agent Name: Mark L. Roden **Date:** _____