

Informal Quote Transmittal

(For Producer Use Only)

Informal Transmittal Guideline for Processing and Expectations

Informal transmittals should only be submitted for the following:

- \$500,000 face amount and/or minimum premium of \$2,000
- Cases that have not been previously declined by two (2) or more carriers.
(Do Not submit cases that have been declined by two (2) or more carriers.)
- For life insurance cases only. Informal transmittals are not accepted by long term care.

Cases that do not meet the above criteria can be submitted by using a Quick Quote request; utilizing the impaired risk questionnaires available in the Impaired Risk section of United Underwriters web site at www.uuinc.com or by calling United Underwriters at 800-258-7296.

After United Underwriters reviews and summarizes the medical information in this transmittal, the potential "best fit" carriers will be determined from the carrier responses.

When applicable, illustrations will be run in advance to see if the client's premium tolerance is within reason.

This information provides a tentative offer. When the case becomes formal, please send it with the tentative offer. However, please be advised that complete underwriting could change the final offer.

Producer Information

Agent Name: _____ Phone #: _____

Contact Person: _____ E-mail: _____

INFORMAL INQUIRY

This is not an application for insurance.

Personal Information:

Proposed Insured Name: _____ Male Female

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____

Have you ever used any tobacco products? Yes No
If yes, what kind? _____ Date last used: _____

Product Information:

Face Amount Desired: \$ _____ Type of Insurance: Term - How many years? _____
 Universal Life Waiver of Premium? Yes No
 Whole Life

List details of any pending or existing coverage below:

Company	Face Amount \$	Rating	Current Premium \$	Plan of Insurance	Replacing Y / N

Have you ever been rated for insurance? Yes No
If yes, why? _____

Have you ever been declined for insurance? Yes No
If yes, why? _____

Important: Why is this case is being submitted on an informal basis? _____

Is this case currently being shopped, or has it been shopped in the past through other sources? Yes No
If yes, provide details below:

Company	Face Amount \$	Rate Offered	Premium \$	Plan of Insurance	Policy Placed Y / N

Agent Information:

Agent Name: _____ Contact Name: _____

Address: _____

Phone #: _____ E-mail: _____

INFORMAL INQUIRY MEDICAL INFORMATION

Please list the physicians you have consulted in the past five years and the reason for your consult. (*Do not include insurance exams.*)

Name, Address & Phone #:	Date:	Reason: Illness & Treatment:	Duration:

Please list any clinics, hospitals, or sanitariums you have ever been treated in and the reason.

Name, Address & Phone #:	Date:	Reason: Illness & Treatment:	Duration:

Who is your personal physician? When did you last consult them and why?

Name, Address & Phone #:	Date:	Reason: Illness & Treatment:	Duration:

Family History

Family Member	Age (if Living)	Age of Death	Cause of Death
Mother			
Father			
Sibling			
Sibling			

Please list any medications you are currently taking:

Please describe any information not listed above that could affect this offer: (ie: avocations, foreign travel, financial, etc.)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

The terms that follow have the respective meanings when used in this Authorization, which is referred to as this form.
INSURANCE SUPPORT ORGANIZATIONS: Medical Information Bureau, Inc. and/or Consumer Reporting Agency
BUREAU: Medical Information Bureau, Inc.

I understand that the life insurance companies named below, their reinsurers, any insurance support organizations, and those persons authorized to represent them may need to collect information on me in regard to proposed coverage.

Therefore, I authorize any: (1) person licensed to provide health care service; (2) hospital; (3) clinic or other medical facility; (4) insurer; (5) reinsurer; (6) insurance support organization; (7) financial source; and (8) employer, to give the types of information listed below when this form is presented. A copy of this form is valid as the original form. I authorize all said sources, except the Bureau, to give such records or knowledge to United Underwriters, Inc.

The types of information will include facts about my: (1) mental and physical health; (2) other insurance coverage; (3) hazardous activities; (4) character; (5) general reputation; (6) mode of living; (7) finances; (8) vocation; and (9) other personal traits.

The life insurance companies named below and their reinsurers will use the information in order to determine whether I am insurable. The insurance agent, too, may use this information to help update and improve my insurance program.

Those parties named in the first paragraph of this form may disclose the information that they have collected. They may disclose this information to: (1) other insurers to which I have applied or may apply; (2) reinsurers; (3) the Bureau; (4) other persons who perform business, professional, or insurance tasks for them. They may also discuss this information as may be otherwise allowed by law.

This Authorization will be valid for two years after the date it is signed. I understand that I or my authorized representative may ask to be given a copy of this form.

Signed at: _____ this _____ day of _____ 20_____.

Witness: _____ Proposed Insured: _____

United Underwriters, Inc. acts as General Agent for the following listed insurance companies:

AIG American General Life	Genworth Life Insurance Company of New York	Mutual of Omaha
Allianz Life Insurance Company of North America	Indianapolis Life	North American Company for Life & Health Ins.
American National	ING: Reliastar/Security Life of Denver	Old Mutual Financial Network
Assurity Life Insurance Company	ING USA Annuity & Life Insurance Company	Prudential Insurance Company
Banner Life	Jefferson Pilot Financial	Reliastar of New York
Companion Life Insurance Company	John Hancock Life Insurance Company	State Life Insurance Company
Coventry First	John Hancock USA	United Home Life
Fidelity Life	Lincoln Benefit Life	United of Omaha
Genworth Life & Annuity Company	Lincoln Financial Group	West Coast Life
Genworth Life Insurance Company	Metlife	William Penn Life

INSTRUCTIONS TO AGENT: THE NOTIFICATION APPEARING BELOW MUST BE GIVEN TO THE PROPOSED INSURED BEFORE OR AT THE TIME OF SIGNATURE.

NOTICE OF INFORMATION PRACTICES

In the course of properly underwriting and administering your insurance coverage, the listed insurance companies will rely heavily on information provided by you. The companies may also seek information from others, such as medical professionals who have treated you. In some situations, and in compliance with applicable law, the insurance companies may disclose necessary items of information to third parties without your specific authorization. You have the right to be told about, and to see and copy if you wish, items of personal information, amendment, or deletion about which appear in the insurance companies files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF THE LISTED INSURANCE COMPANIES AND YOUR AGENT'S INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR WRITTEN REQUEST TO THE APPLICABLE HOME OFFICE.

NOTICE TO PROPOSED INSURED

In connection with your informal inquiry about insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You may request to be interviewed in connection with preparation of this report. Upon written request within a reasonable time after receipt of this notice, detailed information as to the nature and scope of this investigation will be furnished by the consumer reporting agency.

Information regarding your insurability will be treated as confidential. The life insurance companies listed in this Notice or their reinsurers may, however, make a brief report thereon in the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file. Upon receipt of request from you, the Bureau will arrange disclosure of any information it may have in your file. NOTE: (some medical information may have to be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedure set forth in the federal Fair credit Reporting Act. The address of the Bureau's information office is PO Box 105, Essex Station, Boston, MA 02112. Telephone: (617) 426-3660. The companies listed in this Notice or their reinsurers may also release information in their files to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information

(PRINT name of patient) Birthdate _____ SS# _____

Information to be released from:

Name of designated Facility or Provider

Address

Information to be sent to:

Name of designated recipient

Address

City, State, Zip Code Telephone Number

Information to be released:

The most recent five years of pertinent information (Chart notes, labs, x-rays and special tests)

Specific information (Please specify): _____

Purpose for which disclosure is being made: (Please check one of the following)

Insurance Attorney Doctor Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial):

_____ Drug/Alcohol abuse/treatment & diagnosis _____ Sexually Transmitted Disease
_____ HIV/AIDS diagnosis/treatment/testing _____ Mental Illness or Psychiatric
diagnosis/treatment

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE: _____ **DATE** _____
(Patient, Guardian*, or Authorized Representative*)

(* Please provide documents to prove authority to sign on behalf of the patient.)

This authorization will expire 180 days from the date signed.