

Trial Application

For The Professional Appraisal of Insurability
Of Special Risk Life Insurance Clients

AGENCY
SERVICES
INCORPORATED

7980 Courtyard Plaza
Memphis, TN 38119

(901) 767-4271

(800) 777-0988

(901) 685-9811 Fax

Minimum Face Amounts for Evaluation: \$250,000 term/\$100,000 Permanent

Client Information

Name _____ Birthdate _____ Male/Female

Address

City/St/Zip

Height/Weight _____ Tobacco Use? (If yes, what and how much) _____

Social Security Number _____

Agent Name, Address and Telephone Number

Please describe any current or prior health problems your client has:

What is the name and address of your client's doctor(s)?

Dr. _____

Dr. _____

Dr. _____

What type and amount of coverage is your client looking to obtain?

Term _____ Permanent _____ Second-To-Die _____

Face Amount _____

Here are some additional questions that could help us get the best quote:

What medications does your client take? _____

What is your client's occupation? _____

If case is rated, will your client consider a rated policy? _____

Has your client been rated or declined for coverage?

Which company? _____ When? _____

Are there any other companies currently looking at this case? _____

Is there any other information you have that could help us? _____

Please have Authorization for Release of Confidential Health Care Information, along with the HIPAA form, signed, dated and returned with this trial application.

AUTHORIZATION OF RELEASE OF CONFIDENTIAL HEALTH CARE INFORMATION

I hereby authorize any physician or any health care facility that has provided health care services to me and the Medical Information Bureau to release any of my health care information that they maintain to Agency Services, Incorporated, Executive Underwriters, Incorporated, The Marketing Alliance, Incorporated and the life insurance and service companies listed below and their reinsurance companies. I am requesting the release of my confidential health care information to facilitate my purchase of insurance.

A photographic or imaged copy of this authorization and acknowledgement shall be valid as the original and I reserve the right to withdraw this authorization at any future time.

Signature of proposed insured,
or parent or guardian

Date _____

Agency Services, Inc.
Allianz
Assurity Life
Disability Brokerage, LLC
Fidelity Life
Genworth Life and Annuity
J & H Copy Service
Legal & General – Banner Life
MetLife Investors
Nationwide
Principal
Prudential
The Marketing Alliance, Inc.
Union Central Life

American General
Aviva (Indianapolis Life)
AXA-Equitable
Executive Underwriters, Inc.
GD&D, LLC
ING-Reliastar
John Hancock
Lincoln National
Minnesota Life
North American Cos for L &H
Protective Life
Savings Bank Life (SBLI)
Transamerica Life
United of Omaha