



Straight Term Parameters and Submission instructions

Submission Criteria:

- Males only
- Ages 65 to 80
- Minimum Face: \$500,000
- Maximum Face: \$5,000,000
- Standard or Preferred policies only
- Non-Contestable policies only
- Carrier rating "A" or better
- Must have 5 years of term premium remaining
- 46 approved states (No AK, ND, WV or LA cases)
- Premiums during remaining term period not to exceed 1% of face amount

Submission instructions:

- **Complete and forward the following:**
 - Copy of original term policy
 - Copy of original term scheduled premiums (ie. Term illustration)
 - Policy Information Form
 - Insured Health Questionnaire
 - Atlantic Financial HIPAA
 - Atlantic Financial Policy Authorization

- **When all documentation is ready please choose a submission option below:**
 - Scan and email all documents to: jim@atlanticadvantage.com
 - Fax all documents to (860) 331-8551



Initial Policy Information Form

Please use this page to submit initial information about a policy on which you would like an evaluation:

Carrier: _____

Policy Number: _____

Type of policy: _____

Policy class: _____

Face amount: _____

Original issue date: _____

Current annual premium: _____

Next renewal annual premium: _____

Date of next renewal: _____

Age of Insured as of Today: Years: _____ and months: _____

Marital status of insured: _____

Resident state of insured: _____

Gender of insured: _____

Has the insured previously sold a policy: _____

Number of beneficiaries under 18: _____

Comments:



Atlantic Financial HIGHLY CONFIDENTIAL & PROPRIETARY

The Data in this document is used as part of a predictive index that is the Intellectual Property of Atlantic Financial, and subject to Patent Application. The data elements have scores assigned based upon a body of research reports and indices that has been generated and assembled over a seven year period at great expense. The predictive index creates a scoring matrix that correlates to the positioning of the insured's likely positioning on the bell curve of the National Bureau of Vital Statistics mortality tables and morbidity tables.

The information in this document is the highly Confidential and Proprietary Intellectual Property of Atlantic Financial and is not to be disclosed to any person.

Your acceptance of this document signifies the special significance of the Proprietary nature of this data and the constraints placed upon you personally and on your firm as to the safekeeping of this information. It is not to be made available in any form to any person other than an officer of Atlantic Financial.

It is not to be included in any document, report, or used in any summation of information that you may prepare in a manner that selectively or in total allows another person to define the data or make use of the data in any form.

You and your firm are bound by the strictest Non-Disclosure rules and any use of this data will result in legal action taken against you personally and against your firm. This data may not be copied, electronically entered, or communicated in written or verbal form to any person without the express written permission of Atlantic Financial. If you are unwilling or unable to abide by these policies please immediately return this material to Atlantic Financial.



LFF Policy ID:
Date Issued:
Policy Face Amount:
Last Renewal Date:
Premium Amount:

INSURED QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your record.

Policy Identification:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:	/ /	Height	Weight
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				
Issuing or referring Agent:	Date of last physical exam:				

PERSONAL HEALTH HISTORY

Diagnosed Disease:	<input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Liver Disease <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> other				
Immunizations and dates:	<input type="checkbox"/> Tetanus Date:	<input type="checkbox"/> Pneumonia Date:			
	<input type="checkbox"/> Hepatitis Date:	<input type="checkbox"/> Chickenpox Date:			
	<input type="checkbox"/> Influenza Date:	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i> Date:			

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers



Name the Drug	Strength	Frequency Taken

Allergies to medications Yes No

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee <input type="checkbox"/> Tea	<input type="checkbox"/> Cola
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - /day	<input type="checkbox"/> Pipe - /day <input type="checkbox"/> Cigars - /day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	



Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive and/or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY					
	CURRENT AGE OR AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH		CURRENT AGE OR AGE AT DEATH	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH
Father			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		

MENTAL HEALTH		
Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEN ONLY



Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?		

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	
Description #1		
Description #2		
Description #3		
Description #4		

ACTIVITIES		
Do you travel outside of your house or residence? How often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you drive, What make and Model Car do you drive?		
Playing Golf? How often?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Playing Cards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Snow skiing or other Winter Sports?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Camping or Hiking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home workshop/Do it Yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Going to Movies at a Movie Theatre?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Investment Club or other Club activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fishing, Hunting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Describe other activities that you enjoy:		

LIFE STYLE QUESTIONS		
Did you retire? What is or was your occupation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



If you retired, at what age		
Was or is your income over \$100,000 per year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you changed residence in the last ten years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you lost a significant life-partner or relative in the last 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you lost a beloved pet in the last 5 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you pay your own bills and maintain your own checkbook?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use the internet or send email?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cook your own meals or meals for another?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you live in a high-rise? Which floor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is your waist size?		

Agent Sign and Print Name and Date of Signing:	
Agent Signature	Date
Printed Name	

HIPAA AUTHORIZATION TO OBTAIN AND RELEASE HEALTH-RELATED INFORMATION

Records and information obtained will be disclosed to: Atlantic Financial

The purpose of this disclosure is to evaluate my application for insurance, claim benefits, life settlement transactions or other insurance related transactions. I hereby authorize for you to release any and all records regarding genetic testing, H.I.V./AIDS status, drug abuse and alcohol abuse, behavioral health, and mental health. I understand this will not give the ability or inability to condition my treatment, payment, enrollment, or eligibility for benefits.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, or anyone else located at:

Facility Name:

Address:

To release any and all records and information regarding:

Patient's Name:

First

Middle

Last

Other Name Used:

Date of Birth:

Social Security Number:

Specifics to be released:

To be released to and exchanged between the insurance company first named above, and:

Atlantic Financial
171 Market Square, Suite 106, Newington, CT 06111

and their agents, contractors, employees, life expectancy providers, life settlement providers, proposed financing entities, authorized representatives, affiliates, and assignees as necessary to fulfill the purpose of this disclosure.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of six (6) months from my date of signature below or until the request is filled).

I understand I may revoke/cancel this authorization at any time by requesting such of EMSI or (name of facility visiting) _____ in writing at its address stated above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

Date:

Signature of patient/guardian/personal representative/
power of attorney (specify and include copy):

Legal relationship to application:
(Only if signed above by guardian or personal representative)

Witness Signature:
(Only if required)

Witness Required
(Only if marked)

Notary Signature:
(Only if required)

Notary Required
(Only if marked)



AUTHORIZAITON FOR THE RELEASE OF POLICY INFORMATION

_____ insurer, the issuer of policy Number _____ and/or Certificate Number _____ owned by _____ and insuring the life of _____,

To release directly to Atlantic Financial a copy of the policy, forms, riders or amendments of this policy. I respectfully request that you reply immediately to any written request for information or letters required by Atlantic Financial or its agents pertaining to this policy or contract information. I also request that you release any requested information pertaining to this policy verbally over the phone. I agree that this authorization is valid for twelve (12) months from the date thereof, and that a photocopy or facsimile is as valid as an original. I understand that Atlantic Financial could use information released or obtained pursuant to this authorization for the purpose of pursuing and/or completing the sale of a life insurance policy on which I am the owner, and I hereby expressly authorize such use and discloser. I understand that I may withdraw the consent of this authorization under any applicable state statute or regulation.

Signature of Owner _____ Date _____
Printed Name of Owner _____ Social Security Number / TIN Number _____
Signature of Insured _____ Date _____
Printed Name of Insured _____ Social Security Number _____
Signature of Witness _____ Relationship _____
Printed Name of Witness _____ Date Signed _____

Atlantic Financial and the policy owner mutually acknowledge and agree that the Application Life Insurance Evaluation Form is not an offer or a commitment to extend credit in any form. Atlantic Financial is under no obligation to purchase any Life Insurance Policy.

