Synchronize
Powered by Lockton Affinity

Preliminary Health Assessment
For Life, Long-Term Care and Disability Income Replacement

Shorten the timeline!

Filling out the Initial Risk Assessment completely can save time by:

- Better anticipating the best carrier match and the best medical approval class
- Uncovering potential medical issues upfront that may impact the risk to insure
- Determine the preliminary cost information and potential medical issues that may impact the case
- Provide credibility for you as the advisor by having all the facts before proceeding
- Having the ability to pre-fill some information when it's time to take the app!

Instructions:

- Ensure both the advisor name and client name have been entered on the top of each page
- Complete the overview section and goals
- Complete all medical questions fully (***it is important to provide all details to all yes response questions***)
- Fax all pages to Synchronize (763-522-6251)

What you'll receive:

Your experienced Synchronize Case Manager will review the medical history and provide an estimated underwriting class or range for the client risk. Response time can vary depending on the overall medical history. Simple histories can be reviewed in minutes whereas more complex cases may require additional details, clarifications to history noted, or your Synchronize Case Manager may need to survey carriers that can take 2 to 3 days. You will be advised by your Synchronize Case Manager of what to expect.

Once an estimated underwriting class has been determined, your Synchronize Sales Consultant will translate the results to estimated cost and carrier recommendations. Most proposals are delivered within 24 hours of the risk class estimate.

The results of the initial risk assessment are considered reasonably accurate **based upon the information provided and the review of Synchronize staff. At no time are these to be considered formal offers for insurance and are subject to formal underwriting requirements by the issuing carrier.*

Advisor Information:

Name: _____ Phone number: _____-_____-_____

E-mail address: _____

Whom to call with questions, if not the advisor: _____

Client Information:

Client Name: _____ State: _____ ☐ Male ☐ Female DOB: _____/_____/_____

Overview and Case Goals

1. Plan design Goals

What is the purpose of the coverage? ☐ Personal/Family ☐ Business ☐ Loan ☐ Charitable Gift ☐ Other

How much coverage is needed? _____ How long is coverage needed? _____

How was the amount of coverage determined? _____

What is client's premium tolerance? _____

Owner: ☐ Personal ☐ Trust ☐ Corporation

Which is the client's highest priority? ☐ Cost ☐ Cash Value ☐ Guaranteed Death Benefit ☐ Long-term care needs

What plan of insurance is desired? (If not checked, SBG Sales Consultant will make recommendation)

☐ Term ☐ Whole Life ☐ Universal Life ☐ Variable Universal Life ☐ Survivorship ☐ Long-term care

☐ Disability Income ☐ Business Insurance ☐ Buy/Sell ☐ Other: _____

2. Current Insurance Details

Total amount inforce coverage with all companies $ _____

Will this inquiry, if it results in a formal application, replace any existing insurance? ☐ Yes ☐ No

If replacing: Name of Company _____Coverage Amount $_____ Year Issued: _____

Are you planning a Section 1035 exchange? ☐ Yes ☐ No If Yes, provide current cash value $_____

For a valid 1035 exchange, ownership and product must be like-to-like. Attach policy statements or inforce ledger if available.

Would you like SBG to assist in obtaining policy statement or inforce ledger? ☐ Yes ☐ No

Client Medical Information

1. **Build:** Height _____' _____" Weight _____
   Have you had a change in weight by more than 10 pounds in the last 12 months? ☐ Yes ☐ No
   If yes, please indicate your former weight and the reason for the change _____

2. **Nicotine Use: Are you a current user of nicotine in any form?** ☐ Yes ☐ No
   If yes, please indicate form: ☐ Cigarettes ☐ e-Cigarettes ☐ Cigar ☐ Chew ☐ Pipe ☐ Gum/Patch ☐ Marijuana
   Are you a former nicotine user in any form? ☐ Yes ☐ No
   If yes, indicate date last used ____/____/____ and form: ☐ Cigarettes ☐ e-Cigarettes ☐ Cigar ☐ Chew ☐ Pipe ☐ Gum/Patch ☐ Marijuana

3. **Have you ever been diagnosed and/or treated by a licensed medical professional for:**	Yes	No
a) Heart disease, heart murmur, heart failure, chest pain, atrial fibrillation, cardiac bypass, or heart attack?	☐	☐
b) High blood pressure, high cholesterol, or any other disorders of the heart or blood vessels?	☐	☐
c) Cancer, tumor, or cyst malignant or benign or any disorder of the lymph nodes?	☐	☐
d) Any history of leukemia, anemia, clotting disorder or any other blood disorder?	☐	☐
e) Diabetes, thyroid disorder, elevated blood sugar and other endocrine disorder?	☐	☐
f) Asthma, emphysema, sleep apnea, tuberculosis, sarcoidosis, shortness of breath or any other respiratory disorder?	☐	☐
g) Epilepsy, stroke, cerebrovascular disease, paralysis, seizures, fainting or other neurologic disorder?	☐	☐
h) Depression, anxiety, bipolar disorder, schizophrenia, manic disorder or other emotional disorder?	☐	☐
i) Ulcers, colitis, jaundice, hepatitis, cirrhosis, gastrointestinal bleeding, or any other disorder of the stomach, Esophagus, liver, intestinal tract, gallbladder or pancreas?	☐	☐
j) Arthritis, vascular disease, rheumatoid arthritis, systemic lupus, scleroderma, or fibromyalgia?	☐	☐

k) Please list all additional medications and dosages you are currently taking, including prescriptions and herbal supplements: _____

_____

_____

Please provide full details to all yes responses above (use the back of this page if more space is needed):

Question Letter	Date of Diagnosis	Treatment

		Yes	No
4.	**In the past 10 years have you had any hospitalization or surgery for any of the following?**		
a)	Back, spine, knees, shoulders, rotator cuff, or hips?	☐	☐
b)	Neck or brain?	☐	☐
c)	Currently pregnant? (If yes, what trimester? _____)	☐	☐

5. **In the past 10 years have you:**

a) Been treated for drug or alcohol abuse or been advised to limit the use of alcohol or medication prescribed or not? ☐ ☐

b) Used or experimented with cocaine, marijuana, crack, methamphetamines, heroin, hallucinogens, non-prescribed stimulants, depressants, pain medications, or any other narcotic? ☐ ☐

c) Had your Driver's License taken away? ☐ ☐

   a. Been in court ordered treatment? ☐ ☐

   b. Do you currently use alcoholic beverages? (If Yes, please provide type, frequency and amount): ☐ ☐
   Type: _____Frequency: _____Amount: _____

6. **Activities of Daily Living:**

a) Do you require the use of assistive devices for walking such as wheelchair, walker, cane or scooter? ☐ ☐

b) Do you currently drive a car? (if yes, approximate miles per year_____) ☐ ☐

c) Do you require assistance to bathe, dress, cleaning, toileting, finances and taking medications? ☐ ☐

d) Do you have a history of falls in the past 12 months? ☐ ☐

e) Have you had injections for pain management to hips, back, knees, shoulder, spine or other joints? ☐ ☐

7. **Have you now or in the past 2 years participated in:**

a) Piloting an airplane or as a crew member on any non-commercial airplane? ☐ ☐

b) Skydiving, hang-gliding, parachuting, rock or mountain climbing, bungee or base jumping, motorized racing, scuba diving, underwater cave diving, rodeo or bull fighting? ☐ ☐

**A special questionnaire may be required to fully assess the risk for any questions above*

Please provide full details to all yes responses above (use the back of this page if more space is needed):

Question Letter	Date of Diagnosis	Treatment/Medications

8. **Family History: Please provide details for immediate family members (father, mother and siblings):**

Family Member	Age If Living and Health Status	History of Diabetes, Cancer or Heart Disease	Age at Death and Cause

9. **Please list any planned travel dates for the next 12 months or in the last 2 years outside the United States or Canada:**

Dates of travel: _____/_____/_____ to _____/_____/_____ Purpose: ☐ Vacation ☐ Business

Dates of travel: _____/_____/_____ to _____/_____/_____ Purpose: ☐ Vacation ☐ Business

Dates of travel: _____/_____/_____ to _____/_____/_____ Purpose: ☐ Vacation ☐ Business

Dates of travel: _____/_____/_____ to _____/_____/_____ Purpose: ☐ Vacation ☐ Business

Please list countries and cities where you are staying:

_____ Planned length of stay:_____

_____ Planned length of stay:_____

_____ Planned length of stay:_____

_____ Planned length of stay:_____