CBS | BROKERAGE
OUR GOAL IS YOUR LEGACY · EST. 2008 · SHAKOPEE, MINNESOTA

TimeSaver™

Preliminary Inquiry — Not an application for life insurance.

This TimeSaver™ form is used exclusively to gather specific information on a proposed insured as needed 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.

The decision to order records versus moving directly to a formal application is determined by a combination of the product, face amount, and medical history provided.

PERSONAL HISTORY (this section must be completed)

Name | ☐ Male ☐ Female | Social Security Number

Address | City | State | Zip

Date of Birth | Age | Height | Weight | Monthly Earned Income | Net Worth

Occupation

Is the client a Foreign National? ☐ Yes ☐ No | If yes, list country of citizenship

Has the client traveled outside the United States? ☐ Yes ☐ No | If yes, list the countries and dates visited

Please complete the Foreign Travel Questionnaire

Green Card? ☐ Yes ☐ No

Type of Visa

REQUESTED COVERAGE (this section must be completed)

☐ Accelerated Underwriting ☐ Variable Life ☐ Survivorship (please have other proposed insured submit TimeSaver as well)
☐ Guaranteed Universal Life ☐ Whole Life ☐ Long Term Care Rider
☐ Indexed Universal Life ☐ Term, Level Period________________________________

Face amount desired? | Will these premiums be financed? ☐ Yes ☐ No ☐ Possibly

If you are replacing coverage, will there be any 1035 money with this replacement? ☐ Yes ☐ No If yes, what amount will be carried over? ________________

Provide details on pending and in-force coverage:

Company	Policy/Application Date	Personal or Business	Amount	Class/Rating Issued	Current Premium	Do you intend to replace?

Life Settlements: Indicate any activity in the past five years

GOALS OF THE CASE (this section must be completed)

What is the ultimate goal of the case? | What premium is needed to place the case? | Are you in competition? ☐ Yes ☐ No

If Yes, with what companies?

Where has the case been shopped and list the outcome?

Are there any carriers we should not consider?

Please check if applicable
☐ Business Planning
☐ Estate Planning
☐ Charitable Planning
☐ Other________________________

Did you discuss this case with a sales associate? ☐ Yes ☐ No
Did you discuss this case with an Underwriter? ☐ Yes ☐ No
If yes, who?____

Is your client interested in the following?
☐ Annuities
☐ Disability Insurance
☐ Long Term Care Insurance

Please complete the Disability or LTC questionnaire on the website and attach to this TimeSaver

PRODUCER INFORMATION (this section must be completed)

Name | Social Security Number | Producer Number

Address | City | State | Zip

Phone | Fax | Email Address

Have you submitted this case previously? ☐ Yes ☐ No

All pages of the TimeSaver™ must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.

Copyright © 2020 Tellus Brokerage Connections · Variable Life Insurance and Variable Annuities distributed through P.J. Robb Variable Corp. Member FINRA.

CBS | BROKEREGE

OUR GOAL IS YOUR LEGACY · EST. 2008 · SHAKOPEE, MINNESOTA

TimeSaver™

Proposed Insured ____________________

MEDICAL HISTORY (this section must be completed)

Client's primary care physician (name, address, phone)		
Last consultation with primary care physician (date/reason)		
Any ongoing medical treatment (provide dates/details)		
What other physicians has your client consulted during the past five years? Why? (do not include insurance examinations)	Date	Illness/Reason
In what hospitals, clinics, drug/alcohol treatment centers, or other health facilities has your client ever been treated?	Date	Illness/Reason

PATIENT PORTAL INFORMATION (this section must be completed)

1. Does your client know if his/her doctor/medical facility has electronic health record/patient portal capabilities? ☐ Yes ☐ No
2. If **No to question 1**, would he/she be willing to check with the facility as to their portal/electronic records availability to see if he/she would be able to obtain the records? ☐ Yes ☐ No
3. If **Yes to question 1**, to expedite the underwriting process, is the proposed insured already set up/willing to set up a portal account to review these records and provide CBS Brokerage copies of his/her records to help assist with the underwriting process? ☐ Yes ☐ No

If **Yes to questions 2 and 3**, we will let you know which doctor(s)/medical facilities information we need to obtain so that you can advise your client to provide the pertinent medical records to CBS Brokerage at a secure email address.

PRESCRIPTION HISTORY (this section must be completed)

Note: All insurance companies search the prescription database. Learn more at http://bit.ly/rxchecks-CBS.

Prescription name	Date of last fill	Date of initial prescription	Name of prescribing doctor	Why used

FAMILY HISTORY (this section must be completed)

Have any immediate family members (parents, siblings) been diagnosed or died from heart disease, cancer, or diabetes? If yes, provide details below. ☐ Yes ☐ No

Relation (mother, father, brother, sister)	Diagnosis	Approximate age of disease onset	(if deceased) age at death

DRUG AND ALCOHOL USAGE ☐ check here if this section is not applicable

Does your client currently drink alcohol? ☐ Yes ☐ No

Type(s) of Alcohol ____________________

Date of last consumption ____________________

How much per week ____________________

Does your client ever drink substantially more than present? ☐ Yes ☐ No

If yes, when? ____________________

Has your client ever consulted a doctor or received treatment because of alcohol use?

☐ Yes ☐ No If yes, provide details ____________________

Has your client ever used illegal drugs or sought treatment because of drug use? ☐ Yes ☐ No

If yes, provide details ____________________

Type of drug(s) used ____________________ Date of last use ____________________

Refer to our website or contact your Account Manager for additional questionnaires and information.

All pages of the TimeSaver™ must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.

Copyright © 2020 Tellus Brokerage Connections · Variable Life Insurance and Variable Annuities distributed through P.J. Robb Variable Corp. Member FINRA.

CBS | BROKEREAGE

TimeSaver™

Proposed Insured ______________________________

MARIJUANA & CBD OIL USAGE ☐ check here if this section is not applicable

Does your client use marijuana ☐ Yes ☐ No If yes, complete the following:

Purpose ☐ Recreational/Social ☐ Medicinal Frequency______ times per ☐ Day ☐ Month ☐ Year

Delivery Method ☐ Ingested ☐ Vaporized ☐ Inhaled Date Last Used ______________ Why ______________
Why Used

Does your client use CBD oil? ☐ Yes ☐ No If yes, complete the following:

Frequency______ times per ☐ Day ☐ Month ☐ Year Exact type______________ ______mg

Delivery Method ☐ Ingested ☐ Vaporized ☐ Topical Date Last Used ______________ Why ______________

TOBACCO/NICOTINE USAGE ☐ check here if this section is not applicable

Has your client ever smoked cigarettes	Has your client ever used vaping products (e.g. E-cigarettes)
☐ Yes ☐ No If yes, date of last usage:	☐ Yes ☐ No If yes, date of last usage:

Has your client used other tobacco or nicotine containing products (examples: cigars, pipe, snuff, nicotine gum or patch) ☐ Yes ☐ No

If yes, provide types and last date of use:

HAZARDOUS ACTIVITIES ☐ check here if this section is not applicable

Is your client a private pilot? ☐ Yes ☐ No If yes, provide details.	How many total hours has your client flown as Pilot in Command?________	How many hours does your client fly per year? ____________	Does your client have an IFR (instrument flight rating) ☐ Yes ☐ No

Does your client participate in the following activities? (check those that apply)

☐ Scuba Diving ☐ Bungee Jumping ☐ Ultralight Flying ☐ Sky Diving
☐ Mountain Climbing ☐ Hang Gliding ☐ Auto/Motorcycle Racing ☐ Other______________

DRIVING HISTORY ☐ check here if this section is not applicable

DUI/DWI	Reckless Driving	Suspensions	Any moving violations in the last five years?

CANCER ☐ check here if this section is not applicable

Exact name and location of cancer	Stage and grade	Who would have the pathology report

Date/details of treatment/surgery including date of treatment completion and full remission

CORONARY ☐ check here if this section is not applicable

Date of diagnosis or first onset of symptoms	Number of diseased vessels

Dates/details of treatment/surgery (examples: Catheterization, Angioplasty, Bypass)

Date of last stress test, echo, or coronary calcium scan	Results	By whom

Any pain since treatment/surgery

DIABETES ☐ check here if this section is not applicable

Date of diagnosis	Treatment ☐ Diet only ☐ Oral medication ☐ Insulin	Details

Does your client regularly test his/her blood glucose? ☐ Yes ☐ No	Results	Frequency

Latest result of glycohemoglobin (A1C) test __________ mg% Date______________ By whom ______________

Has your client been diagnosed with having protein and/or microalbumin in urine? ☐ Yes ☐ No

Have your client ever had:	Eye trouble ☐ Yes ☐ No	Heart trouble ☐ Yes ☐ No	High blood pressure ☐ Yes ☐ No
Have your client ever had:	Kidney trouble ☐ Yes ☐ No	Neuritis/Neuralgia ☐ Yes ☐ No	Insulin reactions ☐ Yes ☐ No

Refer to our website or contact your Account Manager for additional questionnaires and information.

All pages of the TimeSaver™ must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.

Copyright © 2020 Tellus Brokerage Connections · Variable Life Insurance and Variable Annuities distributed through P.J. Robb Variable Corp. Member FINRA.

CBS | BROKEROAGE

OUR GOAL IS YOUR LEGACY · EST. 2008 · SHAKOPEE, MINNESOTA

TimeSaver™

Proposed Insured ______________________________

OTHER IMPAIRMENTS

Does your client have any impairments that have not been covered in the previous questions (e.g. Crohn's Disease, Epilepsy, Hepatitis, Mental Disorders, Multiple Sclerosis, Sleep Apnea, TIA/CVA, etc.)? If so, please describe below and include additional pages if more space is needed.

Impairment Not Listed	Date of Diagnosis	Treatment Medication(s)	Date of Last Follow-Up & Test Results	Name of Doctor

Refer to our website or contact your Account Manager for additional questionnaires and information.

All pages of the TimeSaver™ must be completed. Inquiry cannot be considered unless authorization is signed by proposed insured.

Copyright © 2020 Tellus Brokerage Connections · Variable Life Insurance and Variable Annuities distributed through P.J. Robb Variable Corp. Member FINRA.