



# Policy Review Authorization

Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Information: \_\_\_\_\_

Policy #: \_\_\_\_\_

Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Owner: \_\_\_\_\_ SS#: \_\_\_\_\_

Please accept this letter as authorization for the below named individual/firm to be provided with any and all information regarding the above referenced policies, including current in-force ledgers.

Agent: \_\_\_\_\_/Specific Solutions

Address: **475 International Drive** \_\_\_\_\_

City: **Williamsville** State: **NY** Zip Code: **14221**

Fax: **716-632-6051**

---

## Authorization

I authorize \_\_\_\_\_/Specific Solutions, Inc. to obtain any and all information, including in-force ledgers.

X \_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Insured

X \_\_\_\_\_  
Signature of Policy Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Insured

# General Information

1.) What is the purpose of your current policy? \_\_\_\_\_

Mortgage Protection\_\_ Family Protection \_\_ Estate Tax Protection \_\_ Income Replacement \_\_

2.) Please circle any of the following conditions that you currently have or have had in the past. Please provide specific details and dates in the spaces provided. Also please note any other health concerns.

Coronary Artery Disease

COPD/Emphysema

Cancer  
(Be Specific)

Cardiac Bypass/Angioplasty/Stent  
Replacement

Heart Attack/Angina

Sarcoidosis

Heart Valve Surgery/Murmurs

Hepatitis B or C

Arrhythmias

Multiple Sclerosis

Atrial Fibrillation

Parkinson's Disease

Stroke/TIA

Lupus/Other Autoimmune Disorders

Crohn's Disease/Ulcerative Colitis

Sleep Apnea

Diabetes Mellitus

Depression/Anxiety/ Bipolar Disorder

---

---

---

---

---

---

---

---

3.) Please list any medications that you are currently taking and the reason why.

---

---

---

---

4.) Do you use Tobacco? Yes\_\_ No \_\_

If yes, what type and how much: \_\_\_\_\_

If no, # of years with no tobacco use: \_\_\_\_\_

5.) Height \_\_\_\_\_ Weight \_\_\_\_\_