



ONE RESOURCE GROUP – SERVICE STANDARDS Trial Application Process

QUALIFICATIONS REQUIRED TO MEET TRIAL PROCESS

- Initial meeting has occurred between agent and the client and the trial need has been identified.
- Anticipated annual target premium must be at least \$10,000
- The client's medical history warrants Custom Insurance Marketing/One Resource Group to order medical requirements/records
- For any situation that does not meet the qualifications in the above bullets, contact the Custom Insurance Marketing/One Resource Group marketing team for assistance on the best solution for your clients' needs

AGENT TASKS - SUBMITTING A TRIAL REQUEST

- Confirm coverage needs with client to include:
 - a. Coverage period required
 - b. Minimum / maximum face amount needed
 - c. Premium tolerance – what is the maximum annual premium outlay
 - d. Purpose for coverage
 - e. Term or permanent insurance
- Complete the following in totality:
 - a. Custom Insurance Marketing/One Resource Group non-medical questionnaire (attachment 1)
 - b. Custom Insurance Marketing/One Resource Group authorization form (attachment 2)
 - c. Trial application (attachment 3)
- Send all forms to One Resource Group, P. O. Box 10660, Ft. Wayne IN 46853-0660

All forms are located on the ORG website; www.orgcorp.com

ORG TASKS/RESPONSIBILITIES

- Trial team reviews the information provided and contacts agent to confirm the needs and expectations of the client/agent and ORG
- Information will be entered on the ORG database to allow the agent to track the trial as information is collected
- Medical records will be ordered - All APS' greater than \$100 in cost MUST be obtained by the writing agent and/or client.
- Trial team case manager will follow up on information every 3 days until all required information is received
- File is transferred to in-house Underwriter for an assessment on which carrier(s) are best suited to submit an informal application
- Case Manager seeks tentative offers from the carriers
- Agent is notified of the offers and awaits a formal application
- Trial case will be closed after 2 weeks or at the time a formal application is received, whichever occurs first

AGENT TASKS/RESPONSIBILITIES

- Assist the Trial team case manager with obtaining medical records when requested
- Receive the offers from ORG and present to client
- Within 2 weeks of receiving information from ORG, notify ORG of desired next steps; offers declined or a formal application will be submitted to pursue tentative offer
- ORG reserves the right to charge back agents for APS expenses on Trial applications that do not go formal



Application for Trial Process – Part I

Proposed Insured		(Please Print)							
a. Full Name (first, middle, last)	b. Gender <input type="checkbox"/> F <input type="checkbox"/> M	c. Date of birth mo/day/yr	d. Social Security Number						
e. Home Address (number, street, state, and Zip code)									
f. Purpose of the Coverage									
g. Plan of Insurance <input type="checkbox"/> Universal Life <input type="checkbox"/> Survivorship Life	<input type="checkbox"/> Term		<input type="checkbox"/> Life Settlement						
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">Level 1</td> <td style="width: 50%; text-align: center;">Level 2</td> </tr> </table>	Level 1	Level 2	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">10</td> <td style="width: 25%; text-align: center;">15</td> <td style="width: 25%; text-align: center;">20</td> <td style="width: 25%; text-align: center;">30</td> </tr> </table>		10	15	20	30	
Level 1	Level 2								
10	15	20	30						
h. Death Benefit Amount		i. Predicted Premium Tolerance							
j. Agent's Name		k. Agency or Affiliation							

l. Tobacco Use: ___ YES ___ NO If yes, please provide type of tobacco and frequency of use: _____



Application for Trial Process – Part I

Additional Insured (only complete when using survivorship products)			(Please Print)
a. Full Name (first, middle, last)	b. Gender <input type="checkbox"/> F <input type="checkbox"/> M	c. Date of birth mo/day/yr	d. Social Security Number
e. Home Address (number, street, state, and Zip code) (if different then primary insured)			
f. Purpose of the Coverage			
g. Death Benefit Amount			



Application for Trial Process – Part II

Non-Medical Questionnaire (continued)

3. Has any person proposed for insurance: (circle conditions that apply)	<u>YES</u>	/	<u>NO</u>
(a) Had an examination, treatment or consultation with physician during the past 5 years?	<input type="checkbox"/>		<input type="checkbox"/>
(b) Been on, or are now on any medications or prescribed diet?	<input type="checkbox"/>		<input type="checkbox"/>
(c) Sought or been advised to seek advice or treatment, or been arrested for the use of drugs or alcohol?	<input type="checkbox"/>		<input type="checkbox"/>
(d) Ever used narcotics, sedatives, depressants, stimulants or hallucinogens, other than under a doctor's prescription and directions?	<input type="checkbox"/>		<input type="checkbox"/>
(e) Ever used marijuana or cocaine, or been arrested for the possession of drugs?	<input type="checkbox"/>		<input type="checkbox"/>
(f) Ever been or is currently a member of any alcohol or drug rehabilitation program?	<input type="checkbox"/>		<input type="checkbox"/>
(g) Ever attempted suicide?	<input type="checkbox"/>		<input type="checkbox"/>
(h) Had a parent who had cancer diabetes, stroke, heart or kidney disease, or who committed suicide? (please show age at onset and/or death)	<input type="checkbox"/>		<input type="checkbox"/>
(i) Been involved in hazardous activities such as flying, scuba diving, sky diving, auto racing, rock climbing, etc?	<input type="checkbox"/>		<input type="checkbox"/>



Application for Trial Process – Part II

Non-Medical Questionnaire (details)

4. Insured	Question Number	Diagnosis	Full Name/Address of Doctor/Facility
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary			
<input type="checkbox"/> Primary <input type="checkbox"/> Secondary			



ONE RESOURCE GROUP CORPORATION

Authorization to Obtain Information/ Waiver and Acknowledgment Form

AUTHORIZATION:

I AUTHORIZE any physician, medical practitioner, hospital, clinic, and other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my minor children to give the Insurance or Reinsurance Companies named below any and all such information. To facilitate rapid submission of such information, I authorize all said sources, except The Medical Information Bureau, Inc. to give such records or knowledge to Custom Insurance Marketing/One Resource Group.

I UNDERSTAND the information obtained by use of this Authorization will be used by Custom Insurance Marketing/One Resource Group and/or the Insurance Companies named below to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Custom Insurance Marketing/One Resource Group or the Insurance Companies named below to any person or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

Advanced Settlements	Companion Life	Lincoln National	Provident Life
AI Credit	Coventry 1 st	Mass Mutual	Pruco
AIG Life	Credit Suisse	Met Life	Prudential
Allianz	Equitable of Iowa	Met Life Investors	Security Life of Denver
American General	Federal Home	Monumental	Reinsurance Co.
American Investors	Fidelity Security	Mutual of Omaha	Standard
American Life & Casualty	Fort Dearborn	NACOLAH	Sun Life of Canada
American National	Fortis	New England	Swiss Reinsurance
Ashar Group, LLC.	General American	New York Life	The Lifeline Program ®
Assurity/Woodmen	Genworth	Old Line Life	Transamerica
Aviva Life Insurance	Gleaner	Old Mutual Financial	United of Omaha
Company	Great American	Network	US Financial
AVS Underwriting, LLC	Hartford	Old Republic	US Life Insurance NY
AXA Equitable Life	Illinois Mutual	Pacific Life	Unum
Insurance	ILSA	Palm Beach Capital	UTC Financial
Bankers United	ING Reliastar	Pan American	Welcome Funds Inc.
Banner Life	ING Southland Life	Penn Mutual	West Coast Life
Berkshire/Guardian	ING USG	Penn Treaty	Western Reserve Life
BMA	Jackson National	Peoples Benefit	William Penn
Capital Growth Specialists,	Jefferson Pilot	Peterson's	Zurich Life
LLC	John Hancock	PFL	21 st Services
Citizens Security	Kanawha	Phoenix Life	4Pluris, LLC.
Cologne Life	Liberty Life	Physicians Mutual	
Reinsurance Co.	Life Equity	Principal Life	
Colorado Bankers	Lincoln Benefit Life	Protective	

WAIVER AND ACKNOWLEDGMENT:

This Waiver and Acknowledgment (the "Waiver") has been signed on the date set forth below by the undersigned (the "Applicant") in favor of Custom Insurance Marketing/One Resource Group, Corp., its successors, assigns, shareholders, directors and employees (collectively "Custom Insurance Marketing/One Resource Group").

Applicant acknowledges, understands and agrees as follows:

- that Applicant has filed an application with Custom Insurance Marketing/One Resource Group intending to secure life insurance from one or more insurance underwriters.
- that, in the course of applying for life insurance coverage, Custom Insurance Marketing/One Resource Group has asked for and received information concerning Applicant's medical condition and history, as well as other information that is of a personal and confidential nature.
- that Custom Insurance Marketing/One Resource Group will provide that information, or parts of it, to a number of potential insurers and their agents, employees and representatives.
- that Custom Insurance Marketing/One Resource Group maintains, or will maintain, an electronic data interchange (the "Interchange") through which certain authorized underwriters and/or other insurance industry representatives (referred to in this Waiver as "Underwriters") may gain access to information concerning persons either covered by or applying for coverage under insurance policies issued and serviced by those Underwriters.
- that Custom Insurance Marketing/One Resource Group will use the Interchange to store some or all of the confidential and personal information Applicant has provided to Custom Insurance Group/One Resource Group, and, therefore, that Underwriters will be able to gain access to that information through the Interchange.
- that the Underwriters will gain access to the Interchange via the Internet or other, similar computer-based telecommunications systems.
- that, even though Custom Insurance Marketing/One Resource Group has in place security measures Custom Insurance Marketing/One Resource Group believes appropriate to protect the Interchange and the information it contains from unauthorized access and use, and even though Custom Insurance Marketing/One Resource Group will continue to upgrade those security measures from time to time as circumstances warrant, Custom Insurance Marketing/One Resource Group can make no guarantee as to Custom Insurance Group/One Resource Group's ability to protect the Interchange and the information it contains from unauthorized access by "hackers" or other persons, who, through wrongful means, may bypass the security measures protecting the integrity of the Interchange.
- that Custom Insurance Marketing/One Resource Group cannot control the use, dissemination, publishing or interpretation of the information contained in the Interchange once that information is gathered by an Underwriter.
- that Applicant will hold harmless from and against any unauthorized access to or use of, by any person or company, any information pertaining to Applicant in Custom Insurance Group/One Resource Group's possession and/or stored on the Interchange.
- that Applicant will indemnify Custom Insurance Marketing/One Resource Group for all costs and expenses incurred by Custom Insurance Marketing/One Resource Group or any of its employees, shareholders, directors, agents or representatives in enforcing this Waiver. Applicant has evidenced his/her acknowledgment, understanding and agreement with respect to the foregoing by signing this document below.

Applicant has evidenced his/her acknowledgment, understanding and agreement with respect to the foregoing by signing this document below.

I ACKNOWLEDGE that I may request to receive a copy of this document.

I AGREE this form shall be valid for two and one half years from the date shown below.

Signed on this date: ____/____/____

Date of Birth: ____/____/____

City: _____ State: _____

Soc. Sec. #: _____-_____-_____

X _____
Signature of Proposed Insured/Parent or Guardian

X _____
Signature of Witness

Printed name of Proposed Insured/Parent or Guardian

ONE RESOURCE GROUP CORPORATION

Privacy Policy

At Custom Insurance Marketing/One Resource Group Corporation, protecting your privacy is very important to us. We are strongly committed to safeguarding the information you provide us and to use it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

Collection of Information

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms, and fact-finding questionnaires;
- Your transactions with us, our affiliates, and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties, including, but not limited to consumer reporting agencies; and
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

Disclosure of Information

We will not share nonpublic personal information concerning our potential, current or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law. Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations, and other product sponsors to effect purchases and sales and allow for the servicing of your account;
- Your agent or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, like banks and other financial institutions with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Record keeping companies.

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure that there are contractual restrictions on their use and disclosure of that information.

Protection of Information

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Custom Insurance Marketing/One Resource Group Corporation, your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.

ONE RESOURCE GROUP CORPORATION

Physicians Listing

Primary Physician:

Physician's Name: _____

Address: _____

City, State ZIP: _____

Phone No.: _____

Secondary Physician:

Physician's Name: _____

Address: _____

City, State ZIP: _____

Phone No.: _____

Tertiary Physician:

Physician's Name: _____

Address: _____

City, State ZIP: _____

Phone No.: _____