SHAW AMERICAN
FINANCIAL CORPORATION

eSignAssist Program

Three Processing Options

The eSignAssist Program consists of three processing options you may choose from depending on your preference and the size of your case. Regardless which option you choose, Shaw American's underwriting team will shepherd the case through the carrier's underwriting process:

1. **Utilize carrier's online process, like VIVE or iGO (short form online application), No minimum premium**
   The first option uses the carrier's online process designed for electronic submission of applications. It is a short form application, and, in most cases, can be completed online in 10 minutes. After the online form is completed, the carrier will call your client directly, complete a full application and determine at that time if an exam or APS is required. Our staff will be available to assist you in setting up the account, and, at your discretion, will participate in a conference call with you and your client to help you complete the electronic application. After a couple of times, you will enjoy the simplicity of the process and will most likely want to complete it yourself at your own convenience.

2. **Concierge Service, Minimum $5,000 Annualized Premium**
   We are proud to offer our concierge service for your larger cases, many of which involve older age clients who may prefer not to use an electronic process. In a conference call or web meeting with you and your client, we will interview your client, complete a full paper app online and email the forms to you and your client to be signed via DocuSign.

3. **Complete the application yourself and use Shaw American's DocuSign, Minimum $1,000 Annualized Premium**
   We still love to process good, old paper applications, so request one to be emailed to you or download it from our website if you prefer this option. Submit a completed application, then call us, and we will scrub it with you and email it via DocuSign to your applicant for signatures.

eSignAssist Form

Are you ready to get started? Send us this form, and you are ready to go.

Schedule an appointment for you and your client with a Shaw American representative

☐ 1. I would like an appointment ASAP. Please, watch for my call in the next 30 minutes.
☐ 2. I would like to schedule an appointment for
Date:_____/_____/_____ **Time**:____:_____ ☐ AM ☐ PM EST
☐ 3. I would like to call at my client's convenience.

Please select one of the following options:

☐ 1. I will utilize carrier's online process, like VIVE or iGO, with Shaw American's assistance. (no minimum premium)
☐ 2. I will utilize the concierge service and complete an application over the phone with one of your staff. (minimum $5,000 annualized premium)
☐ 3. I will complete the paper application myself, scrub it with a Shaw American representative, and use Shaw American's DocuSign service to obtain signatures. Please, send me the forms for _____ carrier. (minimum $1,000 annualized premium)

Client Information

Client's Name: _____

DOB: _____ **Sex:** ☐ **M** ☐ **F** **State Residence:** _____

Phone Numbers: Cell _____ **Home** _____ **Business** _____

Email Address: _____

Proposed Coverage

Carrier: _____

Face Amount: _____ **Plan of Insurance:** _____ **If Term, Years:** _____

Class Quoted: _____ **Premium Quoted:** _____ **Riders:** _____

Will a 3rd Party own this policy? ☐ **Yes** ☐ **No (if yes complete the questions below)**

Owner Type? ☐ **Individual** ☐ **Corporation** ☐ **Revocable Trust** ☐ **Irrevocable Trust**

Who will be signing on behalf of the 3rd Party?

Name:_____ **Title:** _____

Email: _____

Advisor Information

Name (Please Print): _____ **Cell Number:** _____

Last Four Digits SSN: _____ **How long have you known the client**? _____

For concierge cases, $5,000 or more annual premium. By initialing here _____, I agree to the following: The client and I will participate in the telephone interview with the Shaw American representative. I am confirming I provided my client with the appropriate HIPAA requirement, and if the policy is corporately owned, the client was informed of 101j requirements, and they were satisfied.

Shaw American Financial Corp. Authorization for Release of Information
(required for concierge cases only)

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Shaw American Financial Corp and its affiliated agencies, including but not limited to APPs, VIVE, Exam One, Express Imaging Services, Jet Stream, Superior Mobile Medics, Employee Pooling, Shaw American Financial Corp/LifeMark Partners staff physician, LifeMark Partners to disclose my personal financial and health information to the insurance companies listed below. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager, pharmacy related service organization or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, including but not limited to APPs, Examination Management Services (EMSI), Exam One, Express Imaging Services, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, prescription records and history of prescribed medications, but excludes psychotherapy notes. By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Shaw American Financial Corp. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Shaw American Financial Corp and its staff, employees and affiliated companies, not limited to, but including; *AIG, Allianz, American General Life Insurance Company, American Mayflower, American National Insurance Companies, Assurity, Athene, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Financial, Cincinnati Life, Companion Life Insurance Company, Fidelity Life, Foresters, Forethought, Genworth Financial Family of Companies, Global Atlantic, John Hancock, Legal and General, Lincoln Financial Group, Mass Mutual, Minnesota Life, Mutual of Omaha Insurance Companies, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, New York Life, OneAmerica, Principal National Life, Protective Life, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, Reliastar Life, Security Mutual, Sun Life, Symetra, The Savings Bank Life Insurance Company of Massachusetts, Transamerica Insurance & Investment Group, United Home Life, United of Omaha Life Insurance Company, Voya Financial, William Penn Life Insurance Company of New York, Zurich.*

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether I sign the authorization.

I understand that if I refuse to sign this authorization, Shaw American Financial Corp may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

I understand that I can revoke this authorization at any time by giving written notice to the Shaw American Financial Corp at the address shown below. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

_____ _____

Proposed Insured's Name **Proposed Insured's Signature**

_____ _____

Signed and Dated On **At (City, State, Zip Code)**

Agent/ Witness_____

eSignAssist Tips

Please send this to your client to prepare them for their interview with us or the carriers.

The eSignAssist program is quick and easy, and we created the list below to help you prepare for our interview with you. Please have this information available when we call to ensure your application can be fully completed and ready for carrier review.

Medical Information

- Names, addresses, phone numbers of doctors or facilities you have visited within the last5 years
- Reason for visits
- Result of visits
- Any prescriptions you are currently taking (name, dosage and frequency), reason you are taking the medication and who prescribed the medication

Helpful tip: Take a picture of your prescription bottles. This can also help in an emergency especially when you are traveling.

Beneficiary Information

- Name, date of birth, address, phone number, email address and social security number

Helpful tip: Many people like to add their children as contingent beneficiaries but don't have access to their social security numbers. Remember you can always add a contingent beneficiary later when you do have this information.

Existing Insurance

- We will need the carrier name, face amount, date issued, policy number and beneficiary's name(s)

Helpful tip: If you can't locate your insurance policies, look through your bills or bank statements which may have your policy number on them or contact the carrier or your advisor.

Business Information

- If this is a business owned policy, the business Tax ID #, assets, liabilities, gross sales, net income after taxes and fair market value of business or a copy of the business' profit and loss statement
- Date business was established, percentage of business owned, any bankruptcy information, company web address

Personal Financial Information

- Estimated annual income and net worth