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STUDNICKY FINANCIAL

1203 WEST STREET, SUITE B
ANNAPOLIS, MARYLAND 21401

Client Name: _____

Information Kit

Please review the following attachments:

1. Credentials
2. Product Information
3. Client Information
4. Group Coverage Request
5. Group Information
6. Census
7. Individual Underwriting
8. Dependent Information
9. Physician Search

In order to provide your company with the best options and rates suited for your needs, all paperwork should be faxed or emailed to us as soon as possible. If you have any questions, please call us at any of the numbers below!



STUDNICKY FINANCIAL – EMPLOYEE BENEFITS AND INSURANCE PLANNING

Local 410-268-6462 Maryland 410-974-1979 Toll Free 800-974-1979

FAX 410-268-6686 information@StudnickyFinancial.com

Since 1979 – Our Clients Are Our Credentials

CREDENTIALS

When we provide the insurance planning for your family or the benefit package for your company, servicing your account is expected and done without any fees or hidden charges.

Licenses --

Currently licensed in Arizona, California, Colorado, Connecticut, District of Columbia, Delaware, Florida, Georgia, Illinois, Indiana, Maine, Maryland, Michigan, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin.

Satellite Office-

New York: 853 Broadway, Suite 1001, New York, New York 10003

Studnicky Financial currently provides employee benefits and insurance planning to over 500 group accounts.

We look forward to working with you!

Christopher M. Studnicky
Studnicky Financial
1203 West Street, Suite B
Annapolis, Maryland 21401
800.974.1979

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PRODUCT INFORMATION

EMPLOYER + EMPLOYEE BENEFIT PLAN DESIGNS

- ❖ **TAILORED TO YOUR BUDGET**
- ❖ **MAXIMIZING BENEFITS**
- ❖ **REDUCING TAXES**

❖ **LIFE INSURANCE:**

TERM AND PERMANENT POLICIES FOR GROUP AND INDIVIDUAL PROTECTION.

❖ **HEALTH INSURANCE:**

PREFERRED PROVIDER, INDEMNITY & MANAGED CARE PLANS FOR GROUPS AND INDIVIDUALS.

❖ **DISABILITY INSURANCE:**

LOSS OF TIME AND LONG TERM PROFESSIONAL PLANS FOR GROUPS AND INDIVIDUALS.

❖ **CAFETERIA/ SECTION 125 PLANS:**

DESIGNS TO REDUCE EMPLOYER TAXES AND MAXIMIZE EMPLOYEE BENEFITS WITH *PRE-TAX* DOLLAR OUTLAYS.

❖ **SENIOR SERVICES:**

LONG TERM CARE INSURANCE PLANS THAT PROVIDE *BOTH* IN-HOME AND NURSING HOME PROFESSIONAL CARE.

❖ **ESTATE PLANNING:**

ASSISTANCE IN MINIMIZING FEDERAL ESTATE TAXES AND PROTECTING SURVIVOR BENEFITS.

For straightforward answers to all your questions, call us anytime and we will:

◆ *Create A Benefit Package*

◆ *For Your Own Specific Needs*

◆ *At A Cost You Can Afford*

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CLIENT INFORMATION

WE WILL ALWAYS ACT AS YOUR ADVOCATE

For the past two decades, we have always placed our client's welfare first.
In 1979, we started marketing insurance products through a *nationally known career agency*.
Our clients have helped us realize that the career agent and agency have their own interests in mind.

**We on the other hand, work exclusively for you.
Your Objective Come First.**

Short and Long Term for Today and Tomorrow!!!

- **Your financial future is our first concern**

Few people take the time to *read the fine print* in their insurance policies and often, *hundreds of dollars* in benefits are paid incorrectly each year.
Sadly, many people are *sold* policies that *just don't work*.

We present a benefit package for your needs at your cost!!

- **Our benefit plan serves your entire family**

When you become ill or disabled your family becomes involved in every aspect of the care you need in order to recover. Whether it be **life, health, disability or long term care coverage**, your family needs to know how to file your claim in order to receive every benefit in a timely manner.

We file your claim for your family so you can rest and recuperate!!

- **Your family should have value added benefits**

Dependents, spouses, and children are entitled to *value-added benefits* at little or no cost. Knowing how to access these services could be *worth a fortune* to you. You'll have peace of mind and everyone will have *the finest* pre-natal, gynecological, mental health, dental and vision care.

We explain every service in detail so you can access each benefit!!

- **When questions arise call (800) 974-1979**

One call is all it takes to *get common sense answers that cut through the red tape of the Corporate telephone loop*. We resolve general claim questions on a daily basis and at times involve each specific State Insurance Administration if we suspect client abuse.

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GROUP COVERAGE REQUEST

After Information Kit is completed, please inform client that their quote will be completed by the end of the day or the next morning at the latest. Also set up an appointment for the client to come in and discuss their options.

TODAY'S DATE: _____ Time of Call: _____ Call taken by: _____

How were you referred to us? _____

Name: _____ Sex: Male _____ Female _____

Address: _____

City, State, Zip Code: _____

Phone No: _____ Fax: _____

Cell Phone No: _____ Best Time to Call: _____

Date of Birth: _____ Email Address: _____

Employment:

Part-time _____ Full-time _____ Self Employed _____ Date of hire _____ Term Date _____

Employer: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Email Address: _____

Notes: _____

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GROUP INFORMATION

CURRENT INFORMATION

Medical Coverage

Carrier _____ Effective Date _____
Physician Co-Pay _____ RX Co-Pay _____
Hospital Deductible _____ RX Deductible _____
Rates: Ind _____ H/W _____ P/C _____ Family _____

Life and Disability Coverage

Carrier _____ Effective Date _____
Life Benefits _____ Rates _____
Short-Term Benefits _____ Rates _____
Long-Term Benefits _____ Rates _____

Dental Coverage

Carrier _____ Effective Date _____
Physician Co-Pay _____ Deductible _____
Rates: Ind _____ H/W _____ P/C _____ Family _____

Notes: _____

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COVERAGE REQUEST

REQUESTED COVERAGE

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> HEALTH | <input type="checkbox"/> LIFE INSURANCE | <input type="checkbox"/> PREMIUM ONLY PLAN |
| <input type="checkbox"/> DENTAL | <input type="checkbox"/> SHORT-TERM DISABILITY | <input type="checkbox"/> VOLUNTARY BENEFITS |
| <input type="checkbox"/> VISION | <input type="checkbox"/> LONG-TERM DISABILITY | <input type="checkbox"/> RETIREMENT PLANS |

| | NAME | SEX M/F | BIRTH- DATE MM/DD/YY | SOCIAL SECURITY NUMBER | SALARY | EMPLOYEE TITLE | ZIP CODE | STATE | COVERAGE IND, P/C, H/W, FAM |
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COVERAGE REQUEST

| | NAME | SEX M/F | BIRTH- DATE MM/DD/YY | SOCIAL SECURITY NUMBER | SALARY | EMPLOYEE TITLE | ZIP CODE | STATE | COVERAGE IND, P/C, H/W, FAM |
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For Groups of more than 50 employees please make copies of this page

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INDIVIDUAL UNDERWRITING

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ Age _____

Smoker: _____ Non-Smoker: _____

Height: _____ Weight: _____

Primary Physician/Internist: _____ OB/GYN: _____

Any Specialist: _____

Date of Marriage: _____

MEDICATIONS:(Example: Xanax, 0.5mg, 1 x per day)

1. Name _____ Prescribed for _____ Dosage _____ Amount _____
2. Name _____ Prescribed for _____ Dosage _____ Amount _____
3. Name _____ Prescribed for _____ Dosage _____ Amount _____
4. Name _____ Prescribed for _____ Dosage _____ Amount _____

MEDICAL CONDITIONS:

1. Ailment _____ Date of 1st occurrence _____ Treatment Plan _____
2. Ailment _____ Date of 1st occurrence _____ Treatment Plan _____
3. Ailment _____ Date of 1st occurrence _____ Treatment Plan _____

SURGERIES WITHIN THE LAST 2 YRS.

1. Procedure _____ Date _____ Treatment _____ Doctor _____
2. Procedure _____ Date _____ Treatment _____ Doctor _____
3. Procedure _____ Date _____ Treatment _____ Doctor _____

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DEPENDENT INFORMATION

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Smoker: _____ Non-Smoker: _____

Name: _____

Address: _____

Spouse: _____ Child 1 _____ Child 2 _____

Date of Birth: Spouse _____ Child 1 _____ Child 2 _____

Primary Physician/Internist: _____ OB/GYN: _____

Pediatrician: _____ Any Specialist: 1. _____
2. _____

MEDICATIONS:(Example: Xanax, 0.5mg, 1 x per day)

1. Name _____ Prescribed for _____ Dosage _____ Amount _____
2. Name _____ Prescribed for _____ Dosage _____ Amount _____
3. Name _____ Prescribed for _____ Dosage _____ Amount _____
4. Name _____ Prescribed for _____ Dosage _____ Amount _____

MEDICAL CONDITIONS:

1. Name _____ Date _____ Ailment _____ Treatment Plan _____
2. Name _____ Date _____ Ailment _____ Treatment Plan _____
3. Name _____ Date _____ Ailment _____ Treatment Plan _____

SURGERIES WITHIN THE LAST 2 YRS.

1. Name _____ Date _____ Procedure _____ Treatment _____
2. Name _____ Date _____ Procedure _____ Treatment _____
3. Name _____ Date _____ Procedure _____ Treatment _____

If you have more than 2 children, please make copies

PHYSICIAN SEARCH

| | | | | | | |
|-----------------------------|--|-------------------------------------|-------------|--------------|---------------------|--------------------|
| Employee Name- | | | | | | |
| Primary Physician | | | | | | |
| | Provider Name (Last, First) | Physician Group/Hospital | City | State | Zip Code | Phone # |
| Family Physician | | | | | | |
| Internist | | | | | | |
| OB/GYN | | | | | | |
| Pediatrician | | | | | | |
| Dentist | | | | | | |
| General | | | | | | |
| General | | | | | | |
| Pediatrician | | | | | | |
| Orthodontist | | | | | | |
| Specialist | | | | | | |
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| 4. | | | | | | |
| 5. | | | | | | |

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