asap LIFE

Life's Solutions @ gbl — Life, LTC, Disability, Annuities

Helping protect your clients' tomorrows.

Applicant Information			
First Name:	Middle:		Last Name:
DOB:	Save Age? Yes ☐ No ☐	SSN:	Phone:
Current Address:			
City:	State:		Zip Code:
Male ☐ Female ☐	Driver's License #/Issue State:		
Ever Used Tobacco? Yes ☐ No ☐	If Yes, date last used:		Type of Tobacco:
Current Employer:		Occupation/Duties:	
Best Time to Contact Client:		State & Country of Birth:	
Is Insured a U.S. Resident? ☐ Yes ☐ No		Email:	

Proposed Policy Information
Carriers available: ☐ Banner ☐ Cincinnati Life ☐ Principal ☐ Protective ☐ United of Omaha ☐ AIG ☐ Prudential
Plan Name/Plan Duration: — Face Amount:
Rate Class Quoted: — Quoted Premium:
Purpose of Insurance: — If Business Purpose, Business Name:
*Optional Riders: ☐ Waiver of Premium ☐ Accidental Death Benefit Rider - Amount $
☐ Child Rider - # of Units ☐ Disability Benefit Rider - Specified Monthly Premium $
*all riders are not available with all carriers/products.
Does PI want temporary insurance coverage if available? ☐ Yes ☐ No (Not available with Prudential)
If yes, In the past 5 years has the proposed insured had, been treated for, or been advised to be treated for, heart disease, stroke, cancer, or alcohol or drug dependence or abuse? ☐ Yes ☐ No Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? ☐ Yes ☐ No
DO NOT ACCEPT PREMIUM WITH THIS REQUEST FOR LIFE INSURANCE INTERVIEW. IF TIA IS AVAILABLE, PAYMENT MUST BE MADE VIA EFT OR CREDIT CARD (IF AVAILABLE).
Mode of Payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (if monthly, provide info below)
Name of Financial Institution: — Type of Account: ☐ Checking ☐ Savings
Routing Number: — Account Number: — Monthly Draft Date:

Payor Information
Will there be a Payor other than the insured? ☐ Yes ☐ No
Payor Name (if different than proposed insured) — Payor SSN:
Payor Street Address (if different from proposed insured):
City: — State: — Zip Code:

Beneficiary Information				
Name	Relationship	DOB	SSN	Primary/Contingent
				☐Primary ☐Contingent
				☐Primary ☐Contingent
				☐Primary ☐Contingent

Ownership Information (if different from proposed insured)		
First Name: N/A	Middle:	Last Name:
SSN or Tax ID:	Relationship:	DOB:
Street Address:		
City:	State:	Zip Code:
If Trust, Trust Name:		Trust Date:

Financial Information		
Income:	Assets:	Liabilities:
Net Worth:	Annual Interest & Other Income:	
Bankruptcy: Yes ☐ No ☐	If yes, date discharged?	

If Business Purpose:		
Business Assets:	Business Liabilities:	Business Net Worth:
What percentage of the business do you own?		Gross Annual Salary:
Is business insurance applied for or in force on other key members of the business? ☐ Yes ☐ No If yes, explain:		

Existing Coverage - *If none, please state "none."*				
Carrier Name	Face Amount	Year Issued	Policy #	Replacement
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ Yes ☐ No	
Do you have an application pending in another company?	☐ Yes ☐ No
Have you ever had any life or health insurance declined, postponed, or offered other than as applied for?	☐ Yes ☐ No
Is there any intention that any party other than the owner will obtain any right, title or interest in any policy issued on the life of the proposed insured as a result of this application?	☐ Yes ☐ No
For any policy to be issued as a result of this application, will any portion of the initial or future premiums be borrowed, loaned or otherwise financed?	☐ Yes ☐ No
Risk Evaluation	
Do you have a history of alcohol or substance abuse? If yes, date:	☐ Yes ☐ No
Have you had any DUIs in the past 5 years? If yes, date:	☐ Yes ☐ No
Have you had more than two motor vehicle violations in the past 3 years?	☐ Yes ☐ No
Has a parent or a sibling had a history of cardiovascular disease prior to age 60?	☐ Yes ☐ No
If yes, has parent or sibling died as a result of cardiovascular disease prior to age 60?	☐ Yes ☐ No
Height:	Weight:

Producer Information	
First Name:	Last Name:
Phone:	Email:
Did you see the Proposed Insured at point-of-sale? ☐ Yes ☐ No	
Is the Proposed Insured a prior client of yours? ☐ Yes ☐ No	
Knowledge of Proposed Insured: ☐ Self ☐ Know Well ☐ Know Slightly ☐ Met Very Recently ☐ Other_____	
Is the PI an active duty member of the US Armed Forces (including National Guard and Reserve?) ☐ Yes ☐ No	
Is the policy owner, or the person to whom this policy was sold, an active duty service member of the US Armed Forces (including National Guard and Reserve?) ☐ Yes ☐ No	

Disclaimer
This is not an application for life insurance coverage. This is a request to initiate the process. Completing this form will in no way serve to create or commence life insurance coverage. Completing this form does NOT mean that coverage is effective.

Instructions:

Once you have completed the worksheet please fax **(515) 222-5342** or email the form back to **Jennifer Sprague** at **jsprague@grpbenltd.com**