



Applicant Information				
First Name:		Middle:		Last Name:
DOB:	Save Age? Yes <input type="checkbox"/> No <input type="checkbox"/>	SSN:		Phone:
Current Address:				
City:		State:		Zip Code:
Male <input type="checkbox"/> Female <input type="checkbox"/>		Driver's License #/Issue State:		
Ever Used Tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/>		If Yes, date last used:		Type of Tobacco:
Current Employer:			Occupation/Duties:	
Best Time to Contact Client:			Country of Birth:	
Is Insured a U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No			Email:	
Proposed Policy Information				
Carriers available: Banner Cincinnati Life Principal Protective Prudential United of Omaha AIG				
Plan Name/Plan Duration:			Face Amount:	
Rate Class Quoted:			Quoted Premium:	
Purpose of Insurance:			If Business Purpose, Business Name:	
*Optional Riders: <input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Benefit Rider - Amount \$				
<input type="checkbox"/> Child Rider - # of Units <input type="checkbox"/> Disability Benefit Rider - Specified Monthly Premium \$				
*all riders are not available with all carriers/products.				
Does PI want temporary insurance coverage if available? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has a medical physician diagnosed the Proposed Insured as having Hepatitis C or Acquired Immunodeficiency Syndrome (AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>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).</b>				
Mode of Payment: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (if monthly, provide info below)				
Name of Financial Institution:			Type of Account: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
Routing Number:		Account Number:		Monthly Draft Date:
Payor Information				
Will there be a Payor other than the insured? <input type="checkbox"/> Yes <input type="checkbox"/> 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
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
Ownership Information (if different from proposed insured)				
First Name:		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 <input type="checkbox"/> No <input type="checkbox"/>		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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, explain:				
<b>Existing Coverage</b>				
<u>Carrier Name</u>	<u>Face Amount</u>	<u>Year Issued</u>	<u>Policy #</u>	<u>Replacement</u>
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
				<input type="checkbox"/> Y <input type="checkbox"/> N
Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have an application pending in another company?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had any life or health insurance declined, postponed, or offered other than as applied for?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> 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?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Risk Evaluation</b>				
Do you have a history of alcohol or substance abuse? If yes, date:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any DUIs in the past 5 years? If yes, date:				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had more than two motor vehicle violations in the past 3 years?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Has a parent or a sibling had a history of cardiovascular disease prior to age 60?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, has parent or sibling died as a result of cardiovascular disease prior to age 60?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Height:		Weight:		
<b>Producer Information</b>				
First Name:		Last Name:		
Phone:		Email:		
Did you see the Proposed Insured at point-of-sale? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the Proposed Insured a prior client of yours? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Knowledge of Proposed Insured: <input type="checkbox"/> Self <input type="checkbox"/> Know Well <input type="checkbox"/> Know Slightly <input type="checkbox"/> Met Very Recently <input type="checkbox"/> Other _____				
Is the PI an active duty member of the US Armed Forces (including National Guard and Reserve?) <input type="checkbox"/> Yes <input type="checkbox"/> 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?) <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Disclaimer</b>				
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](mailto:jsprague@grpbenltd.com)