

Quick Submit App For Term Insurance

Reset Form

Submit

PROPOSED INSURED INFORMATION

First Name:			Middle:			Last Name:		
Male <input type="checkbox"/> Female <input type="checkbox"/>		Height: ft. in.			Weight:			
Date of Birth:		Birth State/Country:			E-mail:			
Home Phone:		Work Phone:			Cell Phone:			
Current Address:								
City:			State:			ZIP Code:		
Driver's License # / State:			Expires:		U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>		SSN:	
Ever Used Nicotine-Based Products? Yes <input type="checkbox"/> No <input type="checkbox"/>			If Yes, date last used:			Type & Frequency:		
Current Employer:			Occupation:			Workplace ZIP Code:		
Best Time/Date to Contact Client:			Best Phone Number to Call: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell					

PROPOSED POLICY INFORMATION

Select One Carrier: <input type="checkbox"/> American General <input type="checkbox"/> Banner/Wm Penn <input type="checkbox"/> Cincinnati Life <input type="checkbox"/> John Hancock <input type="checkbox"/> Lincoln Financial (LifeElements) <input type="checkbox"/> Pacific Life <input type="checkbox"/> Protective <input type="checkbox"/> Prudential <input type="checkbox"/> United of Omaha								
Term Plan Name / Length:					Face Amount:			
Riders:					App State/Delivery State:			
Mode of Payment: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (Bank Draft)					Modal Premium:			
Owner will be making premium payments using his/her current income. Yes <input type="checkbox"/> No <input type="checkbox"/> Other Method (If No):								
Rate Class Quoted:					Purpose of Insurance:			

PRIMARY BENEFICIARY INFORMATION (1)

Beneficiary Name:					% Share:			
SSN or Tax ID:			Relationship:			DOB/Trust Date:		
Current Address (Check if same as Applicant <input type="checkbox"/>)								

BENEFICIARY INFORMATION (2) - (Use remarks as needed)

- Second Primary Beneficiary
 Contingent Beneficiary

Beneficiary Name:					% Share:			
SSN or Tax ID:			Relationship:			DOB/Trust Date:		
Current Address (Check if same as Applicant <input type="checkbox"/>)								

OWNERSHIP INFORMATION (IF DIFFERENT THAN INSURED)

***Required to collect owners existing life insurance information**

Owner Name:					Signer's E-mail Address:			
SSN or Tax ID:			Relationship:			DOB/Trust Date:		
Current Address:					Phone:		U.S. Citizen? Yes <input type="checkbox"/> No <input type="checkbox"/>	

FINANCIAL INFORMATION

Personal Income:			Assets:			Liabilities:		
Household Income:			Net Worth:			Bankruptcy: No <input type="checkbox"/> Yes <input type="checkbox"/> (Details in Remarks)		

PENDING OR EXISTING LIFE INSURANCE

***If owner other than insured, please also include owner's existing life insurance**

<u>Carrier Name</u>	<u>Face Amount</u>	<u>Contract Type</u> <u>(# of years if term)</u>	<u>Policy #</u>	<u>Year Issued</u>	<u>Replacement?</u>
<input type="checkbox"/> Owner <input type="checkbox"/> Insured					Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Owner <input type="checkbox"/> Insured					Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/> Owner <input type="checkbox"/> Insured					Yes <input type="checkbox"/> No <input type="checkbox"/>

PRIMARY PRODUCER INFORMATION

SPLIT %

First Name:		Last Name:	
Phone:		E-mail:	
Are you related to the Proposed Insured? Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, how?	
Prudential ONLY	Did you see Proposed Insured at the point of sale? Yes <input type="checkbox"/> No <input type="checkbox"/>		Is the Proposed Insured a prior client of yours? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Knowledge of Proposed Insured: <input type="checkbox"/> Self <input type="checkbox"/> Have Never Met <input type="checkbox"/> Know Slightly <input type="checkbox"/> Known Well For _____ <input type="checkbox"/> Other _____		

SECOND PRODUCER INFORMATION (IF APPLICABLE)

SPLIT %

First Name:		Last Name:	
Phone:		Email:	

ADDITIONAL QUESTIONS (Provide additional details in Remarks)

Number of years you have known the Proposed Insured?	
Are you aware of any other information that would adversely affect the Primary Proposed Insured's eligibility?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the plan and amount of insurance identified appropriate in view of the applicant's insurance needs and financial objectives?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have any information that the Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with policy being applied?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has Proposed Insured ever had a request for life or health insurance declined, postponed, or offered other than as applied for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there an 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 <input type="checkbox"/> No <input type="checkbox"/>
Is the Proposed Insured or Owner an active duty member of the U.S. Armed Forces (including National Guard & Reserve)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did you, the Producer(s), comply with all state and company replacement requirements?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I, the Producer, authorize the Company to affix my electronic signature to all life insurance applications and related forms submitted.	Yes <input type="checkbox"/> No <input type="checkbox"/>

REMARKS

*This is a request for life insurance, not a quote request form

Please e-mail completed form to QuickSubmitApp@ubsnet.com or fax to (412) 281-0608