DROP TICKET – FOR ON LINE LIFE INS. APPLICATION SUBMISSION

PROPOSED INSURED:

Date of Birth_____ Gender: ☐ Male ☐ Female - Tobacco User? ☐ Yes ☐ No Quit: year quit_____

Carrier_____ If Term ☐ UL ☐ Term Length 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐

Return of Premium Term: – check here ☐ Risk Class: _____

Child Rider $_____ Waiver of Premium – check here: ☐ SAVING AGE – check here: ☐

Death Benefit $_____Application State:_____

PROPOSED INSURED:

First Name: _____M.I. _____Last Name: _____SS#_____

Home Address: _____ # of years at address _____

City:_____State _____Zip _____

Country of Birth:_____State of Birth (if born in U.S.) _____Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Phone (for phone Interview) Home _____Work _____ Mobile _____

DRIVERS LIC NUMBER_____State issued:_____Expiration Date:_____

Occupation & Duties: _____

Annual Income $_____ Total Net Worth $_____Total Liabilities $_____

Clients Email Address: _____

PRIMARY BENEFICIARY: * ADD BENE SPILTS and CONTINGENT BENEFICARY ON 2ND PAGE UNDER ADDITIONAL INFO.

☐ Individual Name _____ Date of Birth: SS# Address: Phone# Relationship: ○ Spouse ○ Domestic Partner ○ Child ○ Parent ○ Sibling % Share _____%	☐ Business Name _____ Tax ID number: Relationship: ○ Business ○ Partner ○ Employer ○ Employee % Share _____%	☐ Trust Trust Name: _____ _____ Trust Tax ID _____ Trustee(s) _____ _____ % Share_____%	

OWNER:

☐ Proposed Insured

☐ Business Name _____ Address: TAX ID number	☐ Trust Trust Name: _____ Trust Tax ID _____ Date of Trust _____ Trustee(s) _____	

PAYOR:

☐ Proposed Insured ☐ Owner ☐ Other (Name): _____

PAYMENT:

Payment Method ☐ Direct Bill ☐ Electronic Funds Transfer Modal Premium ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (EFT only)

Will the premiums for this policy be loaned or otherwise financed? ☐ Yes ☐ No

CURRENT INSURANCE:

Excluding this application, do you currently have pending insurance with other companies? ☐ Yes ☐ No
Excluding this application, amount of insurance currently pending with other Companies. (If none, state $0) $_____
Of the above pending amount, how much do you intend to accept? $_____
Existing Policy(ies)

Company	Face Amount	Replacing
	$	☐ Yes ☐ No
	$	☐ Yes ☐ No
	$	☐ Yes ☐ No

Will you, or are you likely to, replace, end, or change existing insurance or
Annuity with any company or society with the insurance for which you are applying? ☐ Yes ☐ No

Are there any plans to sell or permanently assign the policy to another person or entity, life settlement provider or an investor?
Or will it replace a policy that has already been sold to another life settlement company or investor? ☐ Yes ☐ No

Medical Info:

Height: Weight: (approximately)

PRIMARY CARE Doctor:

Name_____

Address: _____

Phone number: _____Last date seen: _____Reason:_____

Medications: _____

Specialists:
Name_____

Address_____

Phone number _____Last date seen: _____Reason: _____

Any medical issues or conditions:

Do you drink alcohol? – Yes ☐ NO ☐ If yes – how frequently? _____

ADDITIONAL INFO & bene split and Contingent bene info:

_____

_____

_____