MVP FINANCIAL SERVICES

# Life insurance application intake form

**AGENT MUST COMPLETE WITH CLIENT:** Upon completion, email or fax this form to your contact at MVP Financial Services. **Your client will receive a phone call or a link via email from the carrier to complete all application and medical information, so be sure to let them know to expect this communication.** If you have questions please contact your MVP team. **Avoid Delays-Complete ENTIRE Form.**

Contact MVP

## Advisor Information

| | | |
|---|---|---|
| Advisor Name: | Date This Form Was Completed: | |
| Advisor Email: | Advisor Phone: | Broker/Dealer Affiliation: |
| Advisor SSN: | (SSN is required for advisors submitting their first application through the term-intake process and will be kept confidential under the AimcoR Privacy Policy practices) | |

## Client Information (All Fields Are Required)

| | | | | |
|---|---|---|---|---|
| Insured Name: | | | DOB: | Gender: |
| Marital Status: | Residence State: | Client Birth Country/State: | U.S. Citizen? / If no, status? | |
| Social Security #: | | Address: | | How Long: |
| City: | State: | Zip: | Mobile Phone: | |
| Driver's License State: | Driver's License #: | | Driver's Licenses Exp. Date: | |

Is the Proposed Insured an active duty service member of the U.S. Armed Forces (including National Guard/Reserves)? ☐ Yes ☐ No

Client Email Address:

Height: Weight: Weight change of more than 10 lbs. in the last year? ☐ Yes ☐ No If yes, explain:

Tobacco/Vape History: ☐ Yes ☐ No If yes, indicate type of tobacco and last date of use:

Has the proposed insured ever been treated for the following? Cancer, Heart Disease, Stroke (if yes, indicate date of diagnosis) ☐ Yes ☐ No

### Employment and Income Information

| | | | |
|---|---|---|---|
| Is the Applicant Employed? ☐ Yes ☐ No<br>Employer name and address: | | Job Title: | How Long? |
| Annual Income: | Estimated Total Assets: | Estimated Total Liabilities: | Net Worth: |
| Best Day/Time to Contact Client: | | Preferred phone number:<br>Home ☐ Work ☐ Cell ☐ | |

## Product Information

| | | | | |
|---|---|---|---|---|
| **Please select the carrier and product you are applying with: (for carriers marked with * agent must be contracted first)** | ☐ **AIG*** ☐ **Assurity** ☐ **Banner/LGA** ☐ **John Hancock** *w/ Vitality Rider Y* ☐ *N* ☐ ☐ **Lincoln** ☐ *Elements or* ☐ *Accel* ☐ **PacLife** | | | |
| | ☐ **Principal Business Only** ☐ **Protective** ☐ **Prudential** ☐ **Transamerica** | | ☐ **Term Length:**_____ **or** ☐ **GUL** | |

| | | |
|---|---|---|
| Rate Class Applying for: | Face Amount: $ | Term Rider/Length: $ |
| Rider(s): | Waiver of Premium: | Other (Please specify) : |
| Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT) | | Premium Quoted: $ |

What is the purpose of this insurance? (business, personal, income replacement, key person etc.)

If available, e-Deliver policy? ☐ Yes ☐ No (NOTE: If marked yes, a paper policy will not be issued)

## Owner and Beneficiary Information

If Insured is Not Owner (Please complete): Owner is a ☐ Person ☐ Trust ☐ Corporation ☐ Other Owner mobile:

| | | | |
|---|---|---|---|
| Owner Name / email: | Social Security # / Tax ID: | | |
| Address: | City: | State: | Zip: |
| Relationship to Proposed Insured: | Owner DOB or Trust Date: | | |

| | | | |
|---|---|---|---|
| Primary Beneficiary Name: | DOB: | Relationship: | Percent: % |
| | SSN or TAX ID: | Phone: | |
| Primary / Contingent Beneficiary Name: | DOB: | Relationship: | Percent: % |
| | SSN or TAX ID: | Phone: | |
| Contingent Beneficiary Name: | DOB: | Relationship: | Percent: % |
| | SSN or TAX ID: | Phone: | |

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**Avoid Delays-Complete ENTIRE Form.**

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## Replacement Information

Does the client currently own any life insurance? ☐ Yes ☐ No

If Yes, Is this Policy Replacing any existing coverage? ☐ Yes ☐ No

If Yes, Indicate Reason for Replacement:

Source of Funds for Premium (please be specific):

If Client Has Existing Coverage, Provide Insurance Company(s), Death Benefit(s), Issued Year(s) and Policy Number(s):

Also list pending coverage including company name, amount and purpose.
Indicate if replacement or pending. Use remarks section if necessary:

## Proposed Insured Additional Questions

Total household income (include wages, salaries, investment returns, retirement payouts, and welfare payments): $

Will anyone other than the insured, his or her family, or employer/business partner pay any portion of the initial or future premiums or obtain any right, title, or interest in this policy? ☐ Yes ☐ No If yes, please provide remarks:

Will you submit another application (spouse, business partner, etc.) along with this one? ☐ Yes ☐ No
If Yes, enter Proposed Insured Name:

Will any portion of the initial or future premiums be borrowed, loaned or otherwise financed? ☐ Yes ☐ No

Do you have an application pending in another company? ☐ Yes ☐ No

Agents relationship to the Proposed Insured?

## Additional Information

*Requesting Temporary Insurance/Conditional Coverage? ☐ Yes ☐ No

***If Temporary Insurance (TIAA) or Conditional Coverage is available, it will be determined by most carriers at time of phone interview.**

DO NOT COLLECT ANY MONEY-If requesting Temporary Insurance or Conditional Coverage, please submit a VOIDED check with this Quick Application.

**Or provide the following,** Bank Name: Acct Number: Routing Number:

****Agent is NOT allowed to collect any premium from applicant****

Preferred Draft Date between 1-28:_____ Branch Address/Phone:_____

**If applying for Conditional Coverage with Protective, PLEASE READ TO YOUR CLIENT** the following statement and check the box:

"Please be advised your account will be debited after the paramedical exam is complete. You will have no conditional insurance coverage until such time all the conditions of the Conditional Receipt have been satisfied."

☐ By checking this box, you are indicating that you have read the above disclaimer to your customer and the customer has verbalized their understanding of this information. (If box is not checked, Conditional Coverage will not be considered)

Has the client ever been declined, rated or postponed for life or health insurance? ☐ Yes ☐ No If yes, explain:

How long have you known insured?

Did you meet with the client personally to complete this form? ☐ Yes ☐ No

Was an illustration presented to the insured? ☐ Yes ☐ No

Advisor Instruction/Remarks/Additional Comments:

Authorization Disclaimer: By providing this form to MVP Financial Services, you (writing agent) are attesting to the fact that you do want this insurance request submitted to the carrier on behalf of the applicant.

**For Business Cases**

**Fair Market Value of Business:**_____

**Assets, Liabilities and Net Worth of Business:**_____

**Name, phone and address of personal physician:**_____

Additional Comments:

Contact MVP for questions or submissions: mvp4me.com/your-team Phone 1.630.584.1000