



Request for Life Insurance Interview

* ALL FIELDS MANDATORY

PROPOSED INSURED

_____ XXX-XX-_____ Date of Birth _____ / _____ / _____
 (First Name, Middle, Last Name) (Last 4 digits S.S.#) (Month) (Day) (Year)

RISK EVALUATION

If answer to question is not known, please leave blank. Criteria Questions			Check One Classification For Each Question		
1	1a. Do you have a history of alcohol or substance (drug) abuse?	If No... Check P+ and go to question 2.	If Yes... Go to question 1b.		<input type="checkbox"/> P+ <input type="checkbox"/> P <input type="checkbox"/> S
	1b. Has there been any abuse in the past 10 years?	Check P and go to question 2.	Check S and go to question 2.		
2	Have you had any DUIs in the past 2a. 5 years? 2b. 3 years?	If No... Check P+ and go to question 3.	If Yes... Go to question 2b.		<input type="checkbox"/> P+ <input type="checkbox"/> S+ <input type="checkbox"/> S
		Check S+ and go to question 3.	Check S and go to question 3.		
3	Have you had more than two motor vehicle moving violations in the past three years?	If No... Check P+ and go to question 4.	If Yes... Check S+ and go to question 4.		<input type="checkbox"/> P+ <input type="checkbox"/> S+
4	4a. Has either parent or a sibling had a history of cardiovascular disease before age 60?	If No... Check P+ and go to question 5.	If Yes... Go to question 4b.		
	4b. Has either parent died as a result of cardiovascular disease before age 60?	Check P and go to question 5.	Go to question 4c.		<input type="checkbox"/> P+ <input type="checkbox"/> P <input type="checkbox"/> S+ <input type="checkbox"/> S
	4c. Have both parents died as a result of cardiovascular disease before age 60?	Check S+ and go to question 5.	Check S and go to question 5.		
5	What is your height? _____ weight? _____ Based on height and weight, select the underwriting classification according to the build chart below. If weight meets or exceeds limit for standard (S) class, check S.				<input type="checkbox"/> P+ <input type="checkbox"/> P <input type="checkbox"/> S+ <input type="checkbox"/> S
6	Have you used any nicotine-based products in the past	If No...	If Yes...		
	6a. 36 months?	Check P+ and go to question 7.	Go to question 6b.		<input type="checkbox"/> P+ <input type="checkbox"/> P <input type="checkbox"/> S+ <input type="checkbox"/> PT <input type="checkbox"/> ST
	6b. 24 months? 6c. 12 months?	Check P and go to question 7. Check S+ and go to question 7.	Go to question 6c. Check PT if answers from 1 to 5 are all P/P+, otherwise, check ST.		
7	What is the lowest (on a scale where P+ is highest) underwriting class checked in any of the answers to questions 1-6?	Check one box.			<input type="checkbox"/> P+ <input type="checkbox"/> P <input type="checkbox"/> S+ <input type="checkbox"/> S <input type="checkbox"/> PT <input type="checkbox"/> ST

Build Chart

This questionnaire is designed to provide a tentative premium classification based on a portion of the criteria used to determine a final premium classification. Final approval, classification, and actual rates will be subject to and based upon the entire underwriting process, your medical history, information developed during your interview with the Banner Call Center representative and/or any specific underwriting requirements and criteria. Please refer to the policy form for full disclosure of benefits and limitations. Forms and policy provisions may vary by state. Not available in all states.

Height	Minimum Weight	P+		P		S+		S		Height	Minimum Weight	P+		P		S+		S	
		Male	Female	M/F	M/F	M/F	M/F	Male	Female			M/F	M/F	M/F	M/F				
4'10"	89	135	126	148	156	181	196	5'11"	133	201	175	221	231	272	293				
4'11"	92	140	131	154	162	188	203	6'0"	136	207	180	228	240	280	302				
5'0"	95	144	135	158	166	194	209	6'1"	140	213	184	234	245	288	310				
5'1"	98	148	138	163	172	201	217	6'2"	144	219	188	241	253	295	319				
5'2"	101	153	140	168	175	207	224	6'3"	148	225	193	247	259	304	328				
5'3"	104	158	143	174	182	214	231	6'4"	152	230	197	253	265	312	336				
5'4"	108	163	145	179	188	221	238	6'5"	156	237	201	260	272	320	345				
5'5"	111	168	148	185	194	228	246	6'6"	160	243	205	267	280	328	354				
5'6"	115	174	150	191	200	235	254	6'7"	164	249	209	274	287	337	363				
5'7"	118	179	155	197	206	242	261	6'8"	168	256	214	281	294	345	373				
5'8"	122	185	160	203	212	249	269	6'9"	173	262	218	288	302	354	382				
5'9"	125	190	165	209	219	257	277	6'10"	177	268	222	295	309	363	392				
5'10"	129	196	170	215	226	264	285	6'11"	181	276	226	303	317	372	401				

Legend	
P+	Preferred Plus
P	Preferred
S+	Standard Plus
S	Standard
PT	Preferred Tobacco
ST	Standard Tobacco

PROPOSED INSURED INFORMATION

Proposed Insured

Quoted Premium \$ _____ Face Amount \$ _____

Product (Please check only one.)

OPTerm 10 15 20 25 30

Term Rider 10 15 20

Child Rider 5K 10K

Other _____

Payment method Direct Bill Electronic Funds Transfer (EFT)

Frequency of premium payment Annual Semi-Annual Quarterly Monthly (EFT Only)

Gender Male Female

Is this prospective policy to replace existing insurance? Yes No

If yes to replacing, the existing policy or contract is being replaced because: _____

What is the purpose of this insurance? Buy/Sell Keyman Family Protection Income Replacement

Other _____

Policy Owner (if other than Proposed Insured) Name _____

City, State _____ Zip _____

Date to Save Age Yes No

Waiver of Premium Yes No

TIAA - If your client is eligible, would you like us to offer temporary insurance coverage? Yes No

Exam Provider EMSI ExamOne-Superior Mobile Medics

(Available Interview Hours: Monday - Friday, 9:00 a.m. to 10:30 p.m. ET)

Please contact me: Date _____ Local time: _____ AM PM The Banner Life Call Center will contact you within two hours of the designated time.

Primary Telephone No. _____ Home Work Cell Secondary Telephone No. _____ Home Work Cell

Address _____ (Please Print)

City _____ State _____ Zip Code _____ (Please Print)

E-Mail Address _____ (Please Print)

Remarks:

AGENT INFORMATION

I hereby authorize the Company to affix my electronic signature to all life insurance applications and related forms submitted by the undersigned. I will immediately notify the Company should this authorization for use of this signature or any prior signature authorization be terminated or revoked in any jurisdiction.

X _____ Signature of Agent _____ Date Signed _____

Agent Name _____ Agent # _____ S.S. # _____ - _____ - _____

Telephone # _____ Share of Commission _____

Additional Agent

Agent Name _____ Agent # _____ S.S. # _____ - _____ - _____

Telephone # _____ Share of Commission _____

Brokerage General Agent (BGA) _____ BGA Number _____

Case Manager _____ Case Manager E-Mail Address _____

DISCLAIMER

This is not an application for life insurance coverage. Signing or completing this form will in no way serve to create or commence life insurance coverage. Signing or completing this form does NOT mean that coverage is effective.

Please send the completed form to 3275 Bennett Creek Avenue, Frederick, MD 21704, fax to 301-294-6960 or email to Banner-Submit@lgamerica.com.