LifeEase
BRINGING SIMPLE TO LIFE™

Request for Insurance Application

Questions? Your professional LifeEase Team is here to help at (855) 437-1090 (option 3).

Advisor's Choice
INSURANCE BROKERAGE SERVICES

A Proposed Insured Information

Proposed Insured Name	Social Security Number	Date of Birth / /	Gender ☐ Male ☐ Female
Street Address	City	State	ZIP Code
Home Phone	Driver's License Number/State Issued	Type of Nicotine Use / Date of Last Use	
Business Phone	Email Address		
Cell Phone	**Phone Interview Preferences** Preferred Number to Call ☐ Home ☐ Cell ☐ Business	Preferred Date to Call / /	Preferred Time to Call ☐ am ☐ pm

B Companion or Related Application Information

Is There a Companion or Related Application? ☐ No ☐ Yes. If selected, provide details at right:	Name of Companion Insured	Insurance Type ☐ Permanent ☐ Term

C Policyowner Information

Policyowner Name (If the proposed insured is not the policyowner)	Social Security Number/Trust ID	Date of Birth / /

D Policy Information (Skip if an illustration is being provided with LifeEase)

Carrier	Product Name	Insurance Face Amount (Select one):

Riders
- ☐ Accelerated Death Benefit *(for Terminal Illness)*
- ☐ Accidental Death Benefit
- ☐ Chronic Illness/LTC
- ☐ Child Protection
- ☐ Disability Income
- ☐ Guaranteed Insurability
- ☐ Return of Premium
- ☐ Waiver of Premium
- ☐ Other _____
- ☐ Other _____

Insurance Face Amount (Select one):
- ☐ Specify Face Amount $_____
- ☐ Solve for face amount based on premium and duration. If selected, complete the following:
  Premium $_____
  Duration (Select one):
  - ☐ Specify number of years: _____
  - ☐ To age 100

Product Type (Select One):
- ☐ Long-term Care ☐ Disability

Level Term:
- ☐ Ten Year ☐ Fifteen Year ☐ Twenty Year ☐ Thirty Year

ROP Term:
- ☐ Ten Year ☐ Fifteen Year ☐ Twenty Year ☐ Thirty Year

- ☐ Whole Life
- ☐ Current Assumption UL
- ☐ Guaranteed UL
- ☐ Indexed UL
- ☐ Variable UL

Notes/Remarks

U.S. State in which Application will be Signed	Death Benefit Option (Select One): ☐ Level ☐ Increasing	Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	Modal Premium Quoted $_____

E Health History (If necessary, information can be provided on a separate sheet of paper)

Have you been hospitalized or experienced any adverse health issues in the last seven years?

Please specify the name, dosage and frequency of any medications you are currently taking.

Have any of your parents or siblings died prior to age sixty of a dread disease? (If so, please describe):	Height	Weight

F Beneficiary Information All multiple beneficiary designations will be equally divided among beneficiaries unless otherwise indicated.

Primary Beneficiary Name	Relationship to Proposed Insured	%
Contingent Beneficiary Name	Relationship to Proposed Insured	%

G Replacement Information

Does this policy replace existing Life Insurance? ☐ No ☐ Yes Company Name_____ Policy #_____

H Producer Information Must be completed

Producer Name	Producer Social Security #	Broker Dealer (If applicable)
Producer Phone #	Producer Fax #	Producer Email Address

Email completed form along with illustration to LifeEase@myAdvisorsChoice.com or fax (805) 246-9233