TERM APP EXPRESS FACT FINDER

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Your future. Made easier.®

Use this fact finder to collect the data needed to utilitze the Term App Express online tool.

General Agent/Brokerage Name ______________________________

PROPOSED INSURED INFORMATION

First Name ____________________ Middle ____________ Last Name ____________________

☐ Male ☐ Female SSN ____________________ Birth Date ____________________

Address ______________________________ City ______________ State ______ ZIP ________

Daytime Phone (______)____________Ext. ________ Evening Phone (______)____________ E-mail ______________

PROPOSED OWNER INFORMATION *(If different from the Proposed Insured.)*

Full Name ____________________ Birth/Trust Date ____________ Owner SSN/TIN ______________

Relationship to Insured *(i.e. husband, wife, brother, sister, mother, father, trust, etc.)* ______________________________

Owner is: ☐ Partnership ☐ Individual ☐ Corporation ☐ Trust ☐ Sole Proprietorship Trust State of Incorporation ____________

REPLACEMENT INFORMATION *(Some states have state specific replacement questions in the online tool. NY replacements are not permitted.)*

1. ☐ Yes ☐ No Does the Proposed Insured/Owner have an existing or pending life insurance policy or annuity contract?

If Yes: Company Name ____________________ Coverage Amount $____________ Policy Number ____________ Year Issued ______

1a. ☐ Yes ☐ No Has the Proposed Insured/Owner discontinued making premium payments, surrendered, forfeited, assigned to the insurer, or otherwise terminated this existing policy or contract or is considering doing so?

1b. ☐ Yes ☐ No Is the Proposed Insured/Owner considering using funds from this policy or contract to pay premiums due on the policy being applied for?

TOBACCO USE *(Mark the one item that best describes the Proposed Insured's history of tobacco and other nicotine product use.)*

☐ Use Now **No tobacco or nicotine:** ☐ in the last 5 years ☐ in the last 3 years ☐ in the last 2 years ☐ in the last 1 year

POLICY INFORMATION

Rate Class *(note the rate class for your client)* ____________________ Death Benefit Amount $____________________

☐ TermSmart OR **Term Period:** ☐ 10 Years ☐ 15 Years ☐ 20 Years ☐ 25 Years ☐ 30 Years

☐ ROP Endowment Term **Term Period:** ☐ 20 Years ☐ 25 Years ☐ 30 Years

☐ APL (Automatic Premium Loan) Option *(For ROP Only) - If the policy owner elects the APL Option, they direct the Company to pay premiums due but not paid by the end of the grace period by taking a loan against any available Loan Value.*

Purpose of Insurance: ☐ Personal ☐ Business

☐ Direct Bill OR ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ EFT ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Optional Riders: ☐ Waiver of Premium Rider ☐ Accidental Death Benefit Rider ☐ Child Rider *(Number of units), 1 unit = $1000 of coverage*

Example: Client data obtained by agent. GA completes on-line short application on behalf of agent.
INTERNAL GA USE ONLY. DO NOT SEND THIS TO ING. NO INSURANCE IS BOUND OR PLACED WITH THIS FORM.

 Order #164662 07/31/2012

TEMPORARY INSURANCE AGREEMENT *(STOP, company liability cannot exceed $1M. No binding allowed on any "yes" answers below.)*

☐ Yes ☐ No Would you like a Temporary Insurance Agreement? *Notes: To issue the Temporary Insurance Agreement, the first modal premium will be electronically transferred. The Temporary Insurance Receipt will be in your application packet delivered at the exam appointment.*

1. ☐ Yes ☐ No In the past 10 years had unintentional weight loss, or any symptom(s) or a disease or an impairment for which has not been consulted by a physician?
2. ☐ Yes ☐ No Ever had or now have any type of heart or vascular disease or stroke?
3. ☐ Yes ☐ No Ever had or now have any type of cancer, leukemia, malignancy or any disorder to the brain or immune system?

EFT ONLY (No checks) Bank Name ____________________ Routing # __________________ Account # ____________________ Draft Day __________

BENEFICIARY INFORMATION *(If percentage share are not given, they will be made equal.)*

Full Name ____ Date of Birth/Trust ____________________________

Relationship to Insured *(i.e. husband, wife, brother, sister, mother, father, trust, etc.)* ____

Type of Beneficiary: Beneficiary is: ☐ Individual ☐ Corporation ☐ Trust ☐ Estate of Insured

COMPLIANCE INFORMATION

I acknowledge the following:

a. The proposed insured's medical declaration will be completed by the exam company or the carrier's personal history
b. The proposed owner's government issued ID will be reviewed by the examiner when they conduct the exam and collect signatures,
c. There is no rebate of any kind such as a rebate of premium, to the proposed insured or proposed owner,
d. There have been no discussions in which the proposed owner has been solicited to directly or indirectly sell, assign settle or otherwise transfer the proposed policy (or rights to the death benefit), or an ownership or beneficial interest in an entity that will own the proposed policy, to a life settlement company or third party, and
e. The proposed policy on the life of the proposed insured is not intended to replace a policy that has been sold, assigned, or settled to or with a settlement or viatical company or any other person or entity.

☐ I agree with all of the statements above.

☐ I disagree with some of the or all of the statements above and WILL provide clarification. (Proceed to AGENT ATTESTATION section)

Agent Name ____ Agent SSN *(Optional - Last 4 digits only)* __________ Delivery State __________

AGENT ATTESTATION

1. How long have you known the Proposed Insured? _____________ years   2. ☐ Yes ☐ No Are you related?

3. How much life insurance does the Proposed Insured's spouse own payable to the Proposed Insured or other dependents? $__________________________

4. I state the following:

- I am a duly licensed and appointed (if appointment is required) life insurance agent in the state in which the proposed owner was solicited and in the state in which the policy, if one is issued, will be delivered,
- The plan and amount of insurance identified is suitable in view of the owners' insurance needs and financial objectives,
- The information provided is complete, accurate and correctly recorded,
- All forms required to be delivered at time of solicitation have been delivered, and all other required forms (including the Consumer Privacy Notice and/or sales materials, if necessary) have been or will be provided to the applicant,
- All replacement sales (if applicable) are made in accordance with the Company's corporate policy, and
- If I am not currently appointed, I understand that I will need to be appointed by the Company before the policy, if one is issued, can be delivered.

In addition:

- I authorize the Company representative to obtain such administrative information necessary to complete any life insurance application resulting from this submission, provided, however, that any item of information or question from owner or proposed insured requiring the act or advice of a licensed life insurance agent will be referred to me for action before the application can be completed.
- I will personally review the application created from this information and the administrative information provided by the proposed insured and contact him or her concerning any incomplete or inconsistent information, and will not deliver the policy unless I have completed my review and am satisfied that the policy, application and all attached papers, if any, are complete and accurate.
- I acknowledge that clicking the Agree/Submit button below constitutes my signature on the form and has the same effect as if I personally signed the form.

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COMPLIANCE INFORMATION OVERFLOW FORM

Please provide your explanation for why you disagreed with some or all of the statements in the Compliance Section.

BENEFICIARY INFORMATION OVERFLOW FORM *(If percentage share are not given, they will be made equal.)*

☐ Primary
☐ Contingent

Full Name ______________________ Date of Birth/Trust ______________ Share % ______________

Relationship: **Beneficiary is:** ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

☐ Primary
☐ Contingent

Full Name ______________________ Date of Birth/Trust ______________ Share % ______________

Relationship: **Beneficiary is:** ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

☐ Primary
☐ Contingent

Full Name ______________________ Date of Birth/Trust ______________ Share % ______________

Relationship: **Beneficiary is:** ☐ Spouse ☐ Parent ☐ Sibling ☐ Child

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