

Premium Finance Life

Premium Finance for Life Insurance...



A Division of RTG Consultants,LLC

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Longwood, Florida 32779  
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## SENIOR CASE AGENT SUBMISSION CHECKLIST

**FEASIBILITY STUDY**

Completed and Signed by Client Completed by Agent

**HIPAA FORM**

Signed by Client

**FINANCIAL QUESTIONNAIRE**

Completed by Client

Date Completed and Sent \_\_\_\_\_

Agent Signature \_\_\_\_\_



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## NEW CASE APPLICATION FORM

NAME \_\_\_\_\_

GENDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN# \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_

HOME ADDRESS/PHONE \_\_\_\_\_

CORPORATE TAX IDENTIFICATION \_\_\_\_\_

NET WORTH \_\_\_\_\_

ANNUAL INCOME EARNED \_\_\_\_\_ UNEARNED \_\_\_\_\_

GENERAL HEALTH \_\_\_\_\_ SMOKER (YES or NO) \_\_\_\_\_

### CLIENT'S NEED(S):

PREMIUM FINANCE

ESTATE PRESERVATION

CHARITABLE/ENDOWMENT

DEATH BENEFIT REQUIRED \$ \_\_\_\_\_

\* PLEASE INCLUDE A COMPLETED AND SIGNED HIPAA FORM (SEE ATTACHED)

**AUTHORIZATION:** Information contained in this statement is kept confidential and only used to determine creditworthiness. You granting permission to authorize all inquiries deemed necessary to verify the accuracy of the information contained herein, and to determine the creditworthiness of the undersigned and the undersigned hereby authorizes all persons to whom you make such inquiries to respond thereto in full.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

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## AGENT INFORMATION

AGENT NAME \_\_\_\_\_

AGENT ADDRESS \_\_\_\_\_

AGENT PHONE (WORK & CELL) \_\_\_\_\_ / \_\_\_\_\_

AGENT EMAIL ADDRESS \_\_\_\_\_

## AGENT'S NOTES



**C. Financial Information:**

1. Real Estate (Include home, rental property, mineral interests, condominiums, etc.)

	Approximate			
Location	Name on Title	Market Value	Mortgage	= Equity
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

2. Other "Titled" property, such as autos, boats, etc.

Property Value	Name on Title	Approximate Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Checking Accounts

Name of Bank	Name on Title	Approximate Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Savings Accounts and/or Certificate of Deposit

Name of Bank	Name on Title	Approximate Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Stocks, Bonds or Mutual Funds

Name of Security	Amount	Name on Title	Value
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Stockbroker Name: \_\_\_\_\_ Firm: \_\_\_\_\_

6. IRA's, Profit Sharing Plans, Pension Plans

Location	Name on Title	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Life Insurance and Annuities

Name of Company	Insured	Beneficiary	Policy Amounts
_____	_____	_____	_____


8. Miscellaneous items of value such as limited partnerships, coin collections, antiques, jewelry, contract rights, notes, patents, or other assets not previously listed.

Description of Item	Value

9. Total value of everything you and your spouse own: (add line 1 through 8) \_\_\_\_\_

10. Total amount you and your spouse owe: \_\_\_\_\_

11. Subtract 10 from 9 – TOTAL NET APPROXIMATE WORTH \_\_\_\_\_

**D. Trust Decisions:**

1. My Back-up Trustees and Executors

Who do you want to handle your personal and financial affairs (your estate) if you (and your spouse) cannot?

Trustee

Executor / Trix

#1 Choice: Name: \_\_\_\_\_

Address: \_\_\_\_\_

#2 Choice: Name \_\_\_\_\_

Address: \_\_\_\_\_

**Authorization for Release of Health-Related Information**  
**(This authorization complies with the HIPPA Privacy Rule)**

Name of Proposed Insured/Patient (please print)

Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health provider that has provided payment, treatment or services to or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to American Insurance Services Company, its agents, general agents, employees and representatives. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I terminate any agreements I have made with My Providers to restrict my protected health information and I instruct My Providers to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that the companies listed below may 1) underwrite my application for coverage by making eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with any Company.

This authorization shall remain in force until revoked in writing by the undersigned by sending the request for revocation to American Insurance Services Company, 1400 N. Gannon, Hoffman Estates, IL 60169. I understand that a revocation is not effective if any of My Providers has relied on this authorization. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information. A copy of this authorization is as valid as the original.

Authorization to Release Information to:

Allianz  
American General  
American Group Financial, Inc.  
American Insurance Group  
American Insurance Services Co.  
American National  
AXA  
Aviva  
AVS Underwriting  
BISYS Insurance  
Banker's Life of NY  
Banner Life Insurance Co.  
Brokerage Services Inc.  
Columbia  
Continental Assurance (CAN)  
Empire General Life Ins. Co.  
Equitable Life Assurance Co.  
Fidelity & Guaranty Life  
First Colony Life Insurance  
General American Life  
GE Capital Assurance Co.  
Great American Life Insurance Co.

Guardian Life Insurance Company  
Hartford Life Insurance Company  
Health Care Benefits, Ltd.  
ING  
J & G Associates, Inc.  
Jefferson National  
John Hancock Life  
Kansas City Life  
Life Benefits, Inc.  
Life Solutions  
Lincoln Benefit Life  
Lincoln Life Ins. Co.  
Lincoln Life Ins. Co. of NY  
Lincoln National Life  
Lloyd's of London  
Manulife Financial  
Maple Life  
Massachusetts Mutual  
Metropolitan Life Insurance Co.  
MONY  
Mutual of Omaha  
Nationwide  
New York Life Insurance Co.

Old Line Life Insurance Co.  
Pacific Group LLC  
Pacific Life Insurance Co.  
Pacific Life Insurance Co. of NY  
Penn Mutual  
Phoenix Life Insurance  
Presidential Life  
Principal Life Insurance  
Protective Life  
PRUCO of New Jersey  
Prudential Life Insurance  
Security Mutual Life  
Special Risk Services, Inc.  
Standard of Oregon  
Sun Life of Canada  
Transamerica Occidental Life  
Travelers Life Insurance Company  
21<sup>st</sup> Services  
Union Central  
United of Omaha  
United States Life Insurance  
Union Provident Insurance Co.  
US Financial

Signature of Proposed Insured/Patient/parent or  
Guardian/Personal Representative

Social Security Number

Proposed Insured's Address

Date