

**DO NOT SUBMIT - CHECKLIST FOR TRAINING  
PURPOSES ONLY**



# NORTH CAROLINA

**ASSURANT / AMERICAN MEMORIAL LIFE**

## NEW BUSINESS CHECKLIST

Required Forms Numbers	Description
<input type="checkbox"/> P-1146-R-NC	Application
<input type="checkbox"/> P-1146-R-NC - Page 5	Medical Authorization Form
<input type="checkbox"/> ADM7147A	Replacement Form Number
<input type="checkbox"/> ADM7223-FN	Account Verification Form ( Use if no check/ savings deposit slip available to verify account / routing information is available).
<b>1. Proposed Insured (p. 1)</b>	
<input type="checkbox"/>	Make sure the following is marked on the application.
<input type="checkbox"/>	Legal Name
<input type="checkbox"/>	Mobile Number (for Equis CRM)
<input type="checkbox"/>	Email Address (for Equis CRM)
<input type="checkbox"/>	Age – Age is defined as age on last birthday (current age).
<input type="checkbox"/>	<b>Date of Birth</b>
<input type="checkbox"/>	<b>State of Birth</b>
<input type="checkbox"/>	<b>Social Security Number</b>
<input type="checkbox"/>	Gender
<input type="checkbox"/>	Height
<input type="checkbox"/>	Weight
<input type="checkbox"/>	<b>Citizenship Status*</b> *If answered NO, Immigration Card Number for MIB Check
<input type="checkbox"/>	Previously Applied for Insurance? Y/N
<b>2. Owner Information (p.1)</b>	

<b>Only necessary if owner is different from the proposed insured.</b>	
<b>Disallowed from Ownership:</b>	
<b>Writing Agent - Funeral Home - Trust - Charitable Organization</b>	
<input type="checkbox"/>	<b>Owner Information</b>

### 3. Primary Beneficiary Information (p. 1)

A named beneficiary should be the person who is financially responsible for handling the final arrangements of the proposed insured.

Examples:

- Spouse
- Brother
- Sister
- Grandparent
- Mother
- Father
- Child
- Grandchild
- Responsible Friend or Relative

<input type="checkbox"/>	<b>Primary Beneficiary Name</b>	<b>Note: must have insurable interest</b>
<input type="checkbox"/>	<b>Primary Beneficiary Relationship to Insured</b>	<b>Note: see example designations above - "childhood friend" will not suffice.</b>

### 4. Contingent Beneficiary Information (p. 1)

<input type="checkbox"/>	<b>Indicate Contingent Beneficiary</b>	<b>The person who gets the check if both proposed insured and primary beneficiary expire or the primary beneficiary is unable to receive the funds.</b>
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### 5. Policy Information (p. 1)

<input type="checkbox"/>	<b>Indicate Face Amount</b>
<input type="checkbox"/>	<b>Indicate Premium</b>
<input type="checkbox"/>	<b>Select Effective Date</b>
<input type="checkbox"/>	<b>Plan Type (Graded or Modified)</b>
<input type="checkbox"/>	<b>Nicotine Question Marked?</b>
<input type="checkbox"/>	<b>Replacement Question Marked?</b>
<input type="checkbox"/>	<b>*If Yes, Is Company Name Listed?</b>

<input type="checkbox"/>	Policy Needs to be mailed to the owner unless you have a reason to return (i.e., return visit for annuity opportunity, etc.)	
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**6a. Double Check All Questions (One of these are often skipped in haste) (p. 2)**

<input type="checkbox"/>	Question 1 Marked	
<input type="checkbox"/>	Question 2a Marked	
<input type="checkbox"/>	Question 2b Marked	
<input type="checkbox"/>	Question 2c Marked	
<input type="checkbox"/>	Question 2d Marked	
<input type="checkbox"/>	Question 2e Marked	

**6b. Double Check All Questions (One of these are often skipped in haste) (p. 2)**

<input type="checkbox"/>	Question 1 Marked	
<input type="checkbox"/>	Question 2a Marked	
<input type="checkbox"/>	Question 2b Marked	
<input type="checkbox"/>	Question 2c Marked	
<input type="checkbox"/>	<b>CURRENT PHYSICIAN AND ADDRESS</b>	

**Signature Section (p. 3)**

<input type="checkbox"/>	Signed in City	
<input type="checkbox"/>	Signed in State	
<input type="checkbox"/>	<b>Proposed Insured Signature</b>	
<input type="checkbox"/>	Proposed Insured Signature Date	
<input type="checkbox"/>	Proposed Insured / Policy Owner Signature	
<input type="checkbox"/>	Proposed Insured / Policy Owner Date	
<input type="checkbox"/>	<b>Licensed Agent / Witness Signature</b>	
<input type="checkbox"/>	Licensed Agent Signature Date	
<input type="checkbox"/>	<b>If Owner = Proposed Insured 1 client signature and Dates</b>	
<input type="checkbox"/>	<b>If Owner is different from Proposed Insured 2 Signatures and Dates</b>	

### Agent's Statement Section (p. 3)

- Seen all proposed insured questions marked
- Replacement Question Marked
- Agent's Signature
- Agent State License ID Number
- Agent's Printed Name
- Agent Signed in City
- Agent Signed on Date
- Assurant Agent Number
- Agent Telephone Number

### 7. Payment Options (p. 4)

- Premium Amount Indicated
- Initial Payment Options      **Select Monthly, Quarterly, Semi-Annual, or Annual**
- First Payment Option Selected
- If PAC (Monthly Draft) Date for first draft indicated\* \*\*  
**\* First draft (Must be 1-28, because 29-31 does not occur every in every month on the calendar).**  
**\*\* PAC (Bank Draft) only option available if paying monthly.**

### Medical Authorization (p. 5)

- Name
- Date of Birth
- Signature of Primary Proposed Insured
- Date of Primary Proposed Insured Signature
- Signature of Agent
- Date of Agent Signature

### ADM7147A Replacement Form (2 Copies - Owner / Company)

- Complete Both Copies
- Answer All Yes/ No Questions
- Signature of Primary Proposed Insured / Owner

<input type="checkbox"/>	Date of Primary Proposed Insured Signature	
<input type="checkbox"/>	<b>Signature of Agent</b>	
<input type="checkbox"/>	Date of Agent Signature	

**ADM7223-FN Account Verification Form**

<input type="checkbox"/>	Only complete if no voided check or savings withdrawal slip is available to verify the banking information.	
<input type="checkbox"/>	Insured's Name	
<input type="checkbox"/>	Payor's Name	
<input type="checkbox"/>	Financial Institution Information	
<input type="checkbox"/>	<b>ACCOUNT HOLDER'S SIGNATURE</b>	
<input type="checkbox"/>	Agent Attestation Checkbox	
<input type="checkbox"/>	<b>Agent Signature</b>	