

DO NOT SUBMIT - CHECKLIST FOR TRAINING PURPOSES ONLY



VIRGINIA

ASSURANT / AMERICAN MEMORIAL LIFE

NEW BUSINESS CHECKLIST

Required Forms Numbers	Description
<input type="checkbox"/> P-1146-R-VA	Application
<input type="checkbox"/> P-1146-R-VA - 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).

1. Proposed Insured (p. 1)

<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"/>	Date of Birth	
<input type="checkbox"/>	State of Birth	
<input type="checkbox"/>	Social Security Number	
<input type="checkbox"/>	Gender	
<input type="checkbox"/>	Height	
<input type="checkbox"/>	Weight	
<input type="checkbox"/>	Citizenship Status*	*If answered NO, Immigration Card Number for MIB Check
<input type="checkbox"/>	Previously Applied for Insurance? Y/N	

2. Owner Information (p.1)

Only necessary if owner is different from the proposed insured.

Disallowed from Ownership:

Writing Agent - Funeral Home - Trust - Charitable Organization

Owner Information

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

Primary Beneficiary Name

Note: must have insurable interest

Primary Beneficiary
Relationship to Insured

Note: see example designations above - "childhood friend" will not suffice.

4. Contingent Beneficiary Information (p. 1)

Indicate Contingent
Beneficiary

The person who gets the check if both proposed insured and primary beneficiary expire or the primary beneficiary is unable to receive the funds.

5. Policy Information (p. 1)

Indicate Face Amount

Indicate Premium

Select Effective Date

Plan Type (Graded or
Modified)

Nicotine Question Marked?

Replacement Question Marked?

*If Yes, Is Company
Name Listed?

<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"/>	CURRENT PHYSICIAN AND ADDRESS	

Signature Section (p. 3)

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

Agent's Statement Section (p. 3)

<input type="checkbox"/>	Seen all proposed insured questions marked	
<input type="checkbox"/>	Replacement Question Marked	
<input type="checkbox"/>	Agent's Signature	
<input type="checkbox"/>	Agent State License ID Number	
<input type="checkbox"/>	Agent's Printed Name	
<input type="checkbox"/>	Agent Signed in City	
<input type="checkbox"/>	Agent Signed on Date	
<input type="checkbox"/>	Assurant Agent Number	
<input type="checkbox"/>	Agent Telephone Number	

7. Payment Options (p. 4)

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

Medical Authorization (p. 5)

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

ADM7147A Replacement Form (2 Copies - Owner / Company)

<input type="checkbox"/>	Complete Both Copies	
<input type="checkbox"/>	Answer All Yes/ No Questions	
<input type="checkbox"/>	Signature of Primary Proposed Insured / Owner	

<input type="checkbox"/>	Date of Primary Proposed Insured Signature	
<input type="checkbox"/>	Signature of Agent	
<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"/>	ACCOUNT HOLDER'S SIGNATURE	
<input type="checkbox"/>	Agent Attestation Checkbox	
<input type="checkbox"/>	Agent Signature	