



INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™

POS Agent Worksheet

The purpose of this worksheet is to pre-gather the required information from your client for optimum interview time.

Please keep this form for your records. It does NOT have to be submitted to Royal Neighbors.

Please NOTE that if you have not provided your client a copy of the required Important Information form the interview cannot be conducted.

Agent # _____ % of commissions _____ Agent # _____ % of commissions <i>(Both agents must be active and present in order to split commissions.)</i>
State you will be calling from: _____ Mail Contract to: Agent or Proposed Insured
ID Verification: Did you personally review the ID of the Owner? <input type="checkbox"/> yes <input type="checkbox"/> no Type of ID seen: <input type="checkbox"/> DL <input type="checkbox"/> State ID <input type="checkbox"/> Passport <input type="checkbox"/> Permanent Resident ID # _____
Proposed Insured <i>(P.I. must be Owner and Payor)</i> First name _____ Middle initial ____ Last name _____ DOB _____ SSN _____ Sex <input type="checkbox"/> M <input type="checkbox"/> F Address _____ City _____ State ____ ZIP _____ Phone _____ State/Country of birth _____ U.S. Citizen? <input type="checkbox"/> yes <input type="checkbox"/> no If no, do you have a green card? <input type="checkbox"/> yes <input type="checkbox"/> no Permanent resident ID # _____
For California or Florida only: Do you wish to designate another person to receive copies of any premium lapse notices? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, Name _____ Address _____ City _____ State ____ ZIP _____
Other Insurance: Does the Proposed Insured have any existing life insurance or annuity contracts with this or any other company? <input type="checkbox"/> yes <input type="checkbox"/> no Company _____ <input type="checkbox"/> Life <input type="checkbox"/> Annuity Amount _____ In connection with this application, has there been, or will there be with this or any other company any: surrender transaction; loan, withdrawal, lapse, reduction or redirection of premium/consideration, or change transaction (except conversions) involving an annuity or other life insurance? <input type="checkbox"/> yes <input type="checkbox"/> no
If Replacement: For NAIC States: You need to complete and provide your client with Form 1856-NAIC before the interview starts. Please note if you have not completed and provided your client with Replacement Form 1856-NAIC, Voice Signature of this form will not be available and you will need to submit Form 1856-NAIC to Royal Neighbors after the interview is completed. For Non-NAIC States: Voice signature is not available, please submit the required state form to Royal Neighbors (Non-NAIC states: CA, DE, FL, GA, ID, IL, IN, KS, MI, MN, MO, NV, OK, PA, TN, WA, WY)
Beneficiary*: Primary _____ DOB: _____ Relationship _____ % _____ <input type="checkbox"/> Primary <input type="checkbox"/> Contingent _____ DOB: _____ Relationship _____ % _____ <input type="checkbox"/> Primary <input type="checkbox"/> Contingent _____ DOB: _____ Relationship _____ % _____ <input type="checkbox"/> Primary <input type="checkbox"/> Contingent _____ DOB: _____ Relationship _____ % _____
*Acceptable relationships: <i>(Percentages must be whole numbers.)</i> Spouse, Children, Parent, Sibling, Grandchildren, Aunt/Uncle, Domestic Partner, Estate, Fiance, Funeral Home with address [not allowed in ID, IL, MA, MI, NY, or NV]

Plan: [] Simplified Issue Whole Life [] Graded Death Benefit Face Amount: \$ _____
Rider: [] Accelerated Living Benefit Rider (not allowed in IN, MS, NJ, VT, WA, or if face is below \$7,000)
[] Automatic Premium Loan NOT desired

Has the applicant used tobacco in any form in the last 12 months? [] yes [] no

Payment Quote: \$ _____

EFT Information: Type of Account: [] Checking [] Savings

Electronic payment only – [] Monthly [] Quarterly [] Semi-annual [] Annual

Payment withdrawal day ____ of month OR [] 2nd [] 3rd [] 4th Wednesday of the month

NOTE: If the above EFT withdrawal date has already passed, the draft will occur next month, otherwise advise your client that the draft will occur this month.

Routing Number: _____ Account Number: _____

Physician Name/Clinic that has the most up-to-date information

_____ City _____ State _____ Zip _____

All current medications

Following are the application medical questions that will be asked of your client during interview:

If any answer to questions 2 through 7 is YES, the Proposed Insured is not eligible for ANY coverage.

2. Is the Proposed Insured currently:
 - a. Hospitalized, in a nursing facility, or receiving Hospice Care?
 - b. Confined to a wheelchair, bed, or using oxygen equipment to assist in breathing?
3. Has a member of the medical profession ever diagnosed or treated the Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any immune deficiency disease, or has the Proposed Insured tested positive for the Human Immunodeficiency Virus (HIV)?
4. Has the Proposed Insured ever been diagnosed as having or been treated for:
 - a. Congestive heart failure, or had or been recommended to have a organ transplant?
 - b. Insulin shock, diabetic coma, amputation caused by disease, or taken insulin shots prior to age 30?
 - c. Dementia, Alzheimer's Disease, or mental incapacity?
5. During the past 18 months has the Proposed Insured been diagnosed as having:
 - a. Stroke, aneurysm, cardiomyopathy, or circulatory surgery?
 - b. Angina (chest pain), heart attack or failure, or heart surgery?
6. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:
 - a. Internal Cancer, Melanoma, or Leukemia?
 - b. Cirrhosis, liver disease, kidney failure (including dialysis), chronic kidney disease, or systemic lupus?
7. During the past 18 months, has the Proposed Insured been diagnosed as having:
 - a. A condition expected to result in death within 12 months?
 - b. Been advised by a medical professional to have any diagnostic testing which has not been completed or for which the results have not been received?
 - c. Been recommended by a physician to have treatment or counseling for alcohol or drug abuse?

If question 8 or 9 is YES, only Graded Death Benefit is available.

8. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:
 - a. Stroke, angina (chest pain), heart attack , or cardiomyopathy?
 - b. Heart or circulatory surgery (including pacemaker, heart valve replacement, bypass, angioplasty, stent implant, or any procedure to improve circulation to the heart or brain)?
9. During the past 24 months, has the Proposed Insured been diagnosed as having, or been treated for:
 - a. Emphysema, chronic obstructive pulmonary disease (COPD), or tuberculosis (TB)?
 - b. Neuromuscular disease (include Multiple Sclerosis, Lou Gehrig's Disease, Epilepsy, or Parkinson's Disease)?