

# Eagle Premier Series Worksheet

For use in all states except CA, CT, FL, MN, NY, PA, and VT.

This worksheet is to be used to collect information prior to contacting America's Call Center. Once completed, call the toll-free number at 855.248.8327. All participants (Agent, Proposed Insured, Owner, and Payor) must be on the phone at the time of the call. All calls are recorded.

This worksheet contains sensitive information and should be kept in a secure location for your records or destroyed.

## Agent Information

Name: \_\_\_\_\_ Agent ID #: \_\_\_\_\_

## Proposed Insured Information

Issue State: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female

Name (First, MI, Last): \_\_\_\_\_

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

Street Address (If Mailing Address is a PO BOX): \_\_\_\_\_

If less than 5 years at current address, list prior address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SSN or Taypayer ID: \_\_\_\_\_

Place of Birth (City, State, Country): \_\_\_\_\_



## Owner Information (If different than the Proposed Insured)

Name (First, MI, Last): \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_ SSN or Taypayer ID: \_\_\_\_\_

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

Street Address (If Mailing Address is a PO BOX): \_\_\_\_\_

## Beneficiary Information (% of Share must total 100%. If shares are not given, they will be equal.)

Primary  Contingent % of Share: \_\_\_\_ Name (First, MI, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

Primary  Contingent % of Share: \_\_\_\_ Name (First, MI, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

## Product Information (Not all products are available in all states. See Product Availability Guide for state availability.)

Level  Guaranteed Face Amount \$ \_\_\_\_\_ Effective Date (If Not Current Date): \_\_\_\_/\_\_\_\_/\_\_\_\_

Monthly Premium \$ \_\_\_\_\_  Automatic Premium Loan

If applying for Eagle Premier Level, complete the following information:

1.  Cigarette Smoker  Non-Smoker 2. Height \_\_\_\_\_' \_\_\_\_\_" 3. Weight \_\_\_\_\_ (in pounds)

## Payor Information (Complete only when the Payor is different than the Proposed Insured and Owner.)

Name (First, MI, Last): \_\_\_\_\_ Relationship to Proposed Insured: \_\_\_\_\_

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

Street Address (If Mailing Address is a PO BOX): \_\_\_\_\_

## Bank Information

Name of Financial Institution: \_\_\_\_\_

Checking  Savings Routing Number: \_\_\_\_\_ Account Number: \_\_\_\_\_

## Notes:

Policy Number (Will be provided at the end of the call.)

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**REPLACEMENT INFORMATION**

1. Is there any existing life insurance or annuity coverage on the life of any Proposed Insured? .....  Yes  No  
 If **Yes**, provide information in the table below and answer question 2. If **No**, skip question 2, and proceed to the next applicable section.

Proposed Insured's Name <i>(Last, First, Middle Initial)</i>	Company	Owner <i>(Last, First, Middle Initial)</i>	Amount	Accidental Death Benefit	Policy Date
		<b>VOID</b>			

2. Will the life insurance applied for replace, or otherwise reduce in value, any existing life insurance or annuity now in force? .....  Yes  No  
 Complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application.

**PROPOSED INSURED HEALTH INFORMATION**

1. Have You smoked cigarettes within the last twelve (12) months? .....  Yes  No

2. Height: \_\_\_\_\_ 3. Weight: \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 4. Have You ever been diagnosed, treated, tested positive, or been given medical advice, or prescribed medication by a member of the medical profession for:  |                          |                          |
| a. Alzheimer's disease, dementia, memory loss, muscular dystrophy, or ALS (Lou Gehrig's disease)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Congestive heart failure or cardiomyopathy, chronic kidney disease or kidney failure, or received kidney dialysis? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cirrhosis of the liver, liver failure or other liver diseases (excluding Hepatitis A, B, or C)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic respiratory or lung problem, excluding allergies or asthma? ..   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Metastatic cancer (cancer that has spread to other parts of the body)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Two (2) or more occurrences of cancer of any kind or a reoccurrence of a previous cancer? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. AIDS, ARC, or HIV? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past twenty-four (24) months, have You been diagnosed, treated, tested positive, or been given medical advice by a member of the medical profession for:  |                          |                          |
| a. Internal cancer or malignant melanoma (not basal cell skin cancer)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Complications of diabetes, including amputation, retinopathy (eye disease), nephropathy (kidney disease), neuropathy, insulin shock, or diabetic coma? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic hepatitis or alcoholic hepatitis? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past twenty-four (24) months, have You received a diagnosis, been treated, received medical treatment or counseling, or been prescribed medication by a member of the medical profession for drug or alcohol abuse/dependency or addiction? .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the last twelve (12) months, have You been advised to have tests, surgery or hospitalization (except for those related to HIV or AIDS), which have not been completed, or waiting for a medical diagnosis or results of medical tests or procedures which have not been received? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the past twelve (12) months, have You been diagnosed, treated, tested positive, prescribed medication, or been given medical advice by a member of the medical profession for:  |                          |                          |
| a. Angioplasty (balloon procedure), stent placement, or heart bypass surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Stroke; Heart attack, heart valve disorder, coronary disease, angina (chest pain), or heart disorder (excluding heart murmurs, rhythm disorders, and hypertension)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have You received advice from a member of the medical profession to have, are You waiting for, or have You ever received, an organ or tissue transplant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Are You now, or within the past six (6) months have you been:   |                          |                          |
| a. Hospitalized for 48 hours or more, bedridden or confined to or living in a nursing facility or correctional facility? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Receiving or been advised by a member of the medical profession to receive hospice care? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Receiving home health care for a chronic or debilitating condition? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Confined to a wheelchair or using a walker for a chronic illness (except in the case of a temporary condition that is expected to last three (3) months or less)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Using oxygen to assist in breathing? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have You been diagnosed with a terminal illness that is expected to result in death within twenty-four (24) months? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**ADDITIONAL QUESTIONS FOR APPLICANTS AGE 40-49 ONLY**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 12. Within the past twenty-four (24) months, have You been convicted of, or pled guilty or no contest to, a felony? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Within the past twenty-four (24) months, have You been diagnosed, treated or tested positive, or given medical advice by a member of the medical profession for:   |                          |                          |
| a. Bipolar disorder, schizophrenia, manic or clinical depression, psychosis, mental incapacity, post-traumatic stress disorder or suicidal thoughts? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Brain tumor? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Huntington's disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Within the past twenty-four (24) months, have You used narcotics (other than as prescribed by a member of the medical profession), amphetamines, hallucinogens, heroin, or cocaine? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Within the past twelve (12) months, have You been convicted of or pled guilty or no contest to driving while impaired, intoxicated or under the influence of drugs or alcohol, or had Your driver's license suspended or revoked for any reason? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Within the past twelve (12) months, have You been diagnosed, tested positive, or been given medical advice by a member of the medical profession for chronic pancreatitis? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Do You currently have felony charges pending against You, or are You currently on probation or parole? .....   | <input type="checkbox"/> | <input type="checkbox"/> |