



Illustration Request Form

Broker's information:

Name: _____ Phone Number: _____
Address: _____ Email Address: _____
City: _____ State: _____ Zip: _____

Client's information:

First Insured

Name: _____
Date of Birth: _____
State: _____
Desired Underwriting Class: _____

Second Insured

Name: _____
Date of Birth: _____
State: _____
Desired Underwriting Class: _____

Case objective: (Provide an outline of the case. For example, if using whole life or universal life, please specify if full pay or natural offset, and/or cash value desired at a specific age, etc.)

Competition: (Please provide the name of the carrier, product name, and copy of the illustration to ensure comparable options.)

Plan desired:

Whole Life: _____ Universal Life: _____ Term Life: _____
Face Amount: _____ Premium Amount: _____ 1035 Amount: _____

Riders/special instructions: (Include all riders, additional PUA premium, term blends, years to pay, income stream, specific cash values, etc.)

Pre-qualifying your client

Tobacco use:

Non-smoker _____ Smoker _____ Chewing tobacco _____ Pipes/Cigars _____ E-cigarettes _____

Current use of medication:

Please list the names of all medications, the dosage, the reason of usage, and how long the medication has been used.

Medical history:

Please check the box that is relative to this case.

- | | | |
|--|---|--------------------------------|
| <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Autoimmune System | |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Elevated PSA | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gastrointestinal | |
| <input type="checkbox"/> Sleep Apnea (Mild, Moderate, Severe) | <input type="checkbox"/> Alcohol/Drug History | |
| <input type="checkbox"/> Depression/Anxiety/Bipolar/Other Mental Disorders | <input type="checkbox"/> Migraines | |

Remarks:

Any questions that were answered "Yes" please include all details including year of diagnosis, stages, number of lymph nodes involved (if applicable), the form(s) of treatment(s), and the results of the most recent follow ups.

Avocation activities:

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Scuba Diving | <input type="checkbox"/> Race Car Driving | <input type="checkbox"/> Sky Diving |
| <input type="checkbox"/> Mountain Climbing | <input type="checkbox"/> Pilot | |

Remarks:

Any questions that were answered "Yes" please include all details.

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