

Survivorship Proposal Request



1501 East Woodfield Road, Suite 110E
 Schaumburg, IL 60173-4945
 Phone: 800.605.7566
 Fax: 847.619.9592
 www.resourcebrokerage.com

Broker's Name:	Broker's Phone:	Broker's Fax:
Broker's Address:	Return Quote by: <input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Email	Broker's Email:

Benefit Amount:	Any Riders:
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Permanent (solve for): <input type="checkbox"/> No Lapse <input type="checkbox"/> Cash Value: _____ <input type="checkbox"/> Endow	Term: <input type="checkbox"/> 10yr. <input type="checkbox"/> 20yr. <input type="checkbox"/> 30yr. <input type="checkbox"/> Other
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Applicant One's Name:

Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	DOB: (m/d/yy)	Tobacco/Nicotine: If Yes, Type & Frequency: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Height:	Weight:	Avocation(s):	State Written:
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Class: <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Standard Plus <input type="checkbox"/> Standard	Rated: _____ %
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Health History Applicant One:

Primary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?	Cancer History	Type?
Father			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Mother			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Siblings			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	

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Applicant Two's Name:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		DOB: (m/d/yy)	Tobacco/Nicotine: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Type & Frequency:
Height:	Weight:	Avocation(s):	State Written:

Class: <input type="checkbox"/> Preferred Plus <input type="checkbox"/> Preferred <input type="checkbox"/> Standard Plus <input type="checkbox"/> Standard	Rated: %
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Health History Applicant Two:

Secondary Proposed Insured	Age if Living	Age at Death	Cardiac Conditions or Heart Disease?	Cancer History	Type?
Father			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Mother			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	
Siblings			<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes, age of onset _____ If Yes, date of onset _____	