Insurance Quote Request

Questions? Your professional Advisor's Choice Sales Support Team
is here to help at (855) 437-1090 (option 1).

A Proposed Insured Information

Proposed Insured Name	Insured State of Residence	Date of Birth / /	Gender Male Female

Does the client currently use tobacco products? Yes No	If yes, what type? Cigarettes Cigars Other	If "Other" please specify	How often?
Is client a past tobacco user? Yes No	If yes, what type? Cigarettes Cigars Other	If "Other" please specify	Year quit using tobacco

How many moving violations has the client received in the last three (3) years?

Has the client ever been arrested for driving under the influence of alcohol or drugs? Yes No	If "Yes", specify the month/year of each infraction

B Policy Information (complete this section to the extent of you and your client's preference)

Product Type (Select One):

Level Term:
- Ten Year
- Fifteen Year
- Twenty Year
- Thirty Year

ROP Term:
- Fifteen Year
- Twenty Year
- Thirty Year

Whole Life
Current Assumption UL
Guaranteed UL
Indexed UL
Variable UL

Other ______________________________

Insurance Face and Premium Specifics (Select one):
- Specify Face Amount $__________________
- Solve for face amount based on premium and duration. If selected, complete the following: Premium $__________________

Premium Payment Period (Select one)
- Specify number of years __________________
- To age 100

Riders
- Accelerated Death Benefit *(for Terminal Illness)*
- Accidental Death Benefit
- Chronic Illness
- Long Term Care
- Child Protection
- Disability Income
- Guaranteed Insurability
- Return of Premium
- Waiver of Premium
- Other __________________

Additional First Year Premium $ __________________

Is this a 1035 Rollover? Yes No

Notes/Remarks

U.S. State in which Application will be Signed	Death Benefit Option (Select One) Level Increasing	Payment Mode Annual Quarterly Semi-Annual Monthly EFT

C Health History (If none provided, the proposed insured is assumed best class preferred.)

Has the proposed insured ever been hospitalized or experienced any adverse health issues in the last seven years?

Please specify the name, dosage and frequency of any medications the proposed insured is currently taking.

Are there any occurances of death from parents or siblings prior to age sixty of a major disease? (If so, please describe)	Height	Weight

D Companion or Related Application Information

Is There a Companion or Related Application? No Yes. If yes, complete info at right	Relationship to Proposed Insured	Separate Quote Request for Companion? Yes No

E Policyowner Information

Policyowner Name (If the proposed insured is not the policyowner)	Relationship to Proposed Insured

F Replacement Information

Will this be in replacement of an existing policy? Yes No Company Name__________________Type of Policy __________________

G Producer Information Must be completed

Producer Name	Contact Person Name (if different from Producer)	Broker Dealer (If applicable)
Producer Phone #	Producer Fax #	Producer Email Address

Specify Date / Time Need By

Email completed form to salessupport@myAdvisorsChoice.com or fax to (805) 246-9233

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