

POS Illustration Request Form
(GENERAL AGENT/AGENT USE ONLY)

DATE REQUESTED: _____

FAX TO: Policy Owner Service Dept.FAX #: 855-784-1586

TO PREVENT UNNECESSARY DELAYS, LEGIBLY COMPLETE ALL INFORMATION FIELDS BELOW.
PLEASE NOTE THAT ALL REQUESTS ARE PROCESSED IN DATE ORDER AND YOU SHOULD ALLOW A
MINIMUM OF 5 BUSINESS DAYS FOR PROCESSING YOUR REQUEST

REQUESTED BY: _____ INSURED _____ OTHER Authorization Of Policyowner is required ATTACHED _____ YES _____ NO_____ AGENT/GA – MUST Include GA or Agent Identification number: _____

NAME OF REQUESTOR / RELATIONSHIP TO POLICYOWNER: _____

PHONE NUMBER: (____) _____

FAX NUMBER: (____) _____

MAILING ADDRESS: (Include city, state & zip) _____

EMAIL ADDRESS: _____

PREFERRED METHOD TO RETURN REQUEST TO YOU: _____ REGULAR MAIL _____ FAX _____ EMAIL

POLICY NUMBER: _____ INSURED: _____

PURPOSE OF THE ILLUSTRATION (Add an additional page if more space is needed):

ARE THERE INTENTIONS TO SELL THIS POLICY? _____ YES _____ NO

IF SO, TO WHOM: *Insert name of person and/or company purchasing, include address, phone number and website (if applicable)*

IS VERIFICATION OF COVERAGE BEING REQUESTED/ATTACHED

_____ YES _____ NO

AUTHORIZATION ATTACHED

_____ YES _____ NO

OTHER ATTACHMENTS

_____ YES _____ NO

Please read the following disclaimer before completing and signing below.

We agree that my/our signature(s) below shall apply to each request, which has been checked on this form. Notice to any person who, with intent to defraud or knowing that he is/may be facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

REQUESTOR (Print Name): _____ SIGNATURE: _____

HOME OFFICE USE ONLY—DO NOT COMPLETE BELOW THIS LINE

PLAN	DEATH BENEFIT OPTION	CLASS
EFFECTIVE DATE	DURATION/YEARS	DURATION/MONTHS
ISSUE STATE	ACCOUNT VALUE LAST MAV	
SEX ISSUE AGE	MODE OF PAYMENT	MODAL PREMIUM
FACE AMOUNT	RATING	RIDERS
COMPLETED BY	COMPLETION DATE	