

NEW BUSINESS TRANSMITTAL FORM



Insured Information

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|----------------------|------|
| Proposed Insured #1: | DOB: |
| Proposed Insured #2: | DOB: |

Carrier Information

| | | |
|---|---|--------|
| Carrier Name: | Product Applied For: | |
| Death Benefit Applied For: \$ | Modal Premium (A, S, Q, M): | |
| Underwriting Class Applied For: | PI #1: | PI #2: |
| 1035 Funds: <input type="checkbox"/> Yes <input type="checkbox"/> No | Cash w/Application: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount: \$ | |
| Riders Selected (please specify): | | |
| Illustration Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No (Note: Be sure the illustration matches the carrier application.) | | |

Medical Requirements*

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|---|-----------------------|
| *REQUIRED information, please check one: <input type="checkbox"/> AMS FOR LIFE TO ORDER REQUIREMENTS <input type="checkbox"/> AGENT TO ORDER REQUIREMENTS <input type="checkbox"/> REQUIREMENTS ATTACHED | Special Instructions: |
|---|-----------------------|

Agent Information

| | | |
|--|--|------------------|
| Agent Name: | Phone: | |
| E-mail: | | |
| Agent Number: <input type="checkbox"/> Pending | Split Case: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Agent #1 Name: | Agent #: | Percent Split %: |
| Agent #2 Name: | Agent #: | Percent Split %: |
| Agent #3 Name: | Agent #: | Percent Split %: |
| Notes: | | |

Phone: (866) 546-5267 Fax: (858) 207-1793*

Directions: Fully complete form and mail application and related documents to:

AMS For Life, 15050 Avenue of Science, Suite 100, San Diego, CA 92128

**Applications can only be faxed if allowed by the carrier.*