PRE-QUALIFYING WORKSHEET

(This worksheet is not to be provided to, or completed by, a prospective policyseller or the person(s) insured)

All information requested below, as well as signed authorization meeting our needs, must be provided to us in order for us to properly consider the proposed transaction. Any person who knowingly presents false information in an application for insurance or settlement contract, or this Pre-Qualification Worksheet, may be guilty of a crime and may be subject to fines and imprisonment.

INFORMATION REGARDING PROSPECTIVE POLICYSELLER & POLICY

FULL LEGAL NAME OF POLICYOWNER (First, Middle, Last)			GENDER M ☐ F ☐	MARITAL STATUS
SOCIAL SECURITY OR TAX IDENTIFICATION NUMBER			DATE OF BIRTH MM/DD/YYYY	TELEPHONE
CURRENT RESIDENTIAL (IF PERSON) OR BUSINESS (IF ENTITY) STREET ADDRESS (Do not provide a Post Office Box address)				
CITY			STATE	ZIP CODE
HAS THE POLICYOWNER EVER DIVORCED OR BEEN DECLARED BANKRUPT? DIVORCE: YES ☐ NO ☐	BANKRUPTCY: ☐ YES ☐		PLEASE INCLUDE A LEGIBLE COPY OF VALID, CURRENT PHOTO ID & SS CARD ☐	
NAME OF INSURANCE COMPANY			POLICY NUMBER POLICY TYPE (circle one) TERM UL WHOLE VUL JOINT OTHER	
DATE OF ISSUE MM/DD/YYYY	POLICY FACE VALUE $	ANNUAL PREMIUM $	SURRENDER VALUE $	LOAN AMOUNT $
IS THIS A CONVERTED POLICY? IF YES, INDICATE ORIGINAL ISSUER & NUMBER HERE YES ☐ NO ☐			ORIGINAL ISSUE DATE (IF A CONVERSION)	MM/DD/YYYY

INFORMATION REGARDING THE INSURED

FULL LEGAL NAME OF INSURED (IF THE INSURED IS THE SELLER, WRITE SAME)	GENDER M ☐ F ☐	LEGIBLE COPY OF VALID, CURRENT ID ☐
SOCIAL SECURITY NUMBER	DATE OF BIRTH MM/DD/YYYY	COPY OF SOCIAL SECURITY CARD ☐
CURRENT RESIDENTIAL STREET ADDRESS (Do not provide a Post Office Box address)		
CITY	STATE	ZIP CODE

INFORMATION REGARDING ATTENDING CARE PROVIDERS OF THE INSURED

(1) NAME OF PRIMARY CARE PROVIDER TO INSURED	SPECIALTY, IF ANY, OF ATTENDING CARE PROVIDER
NAME OF FACILITY OR PRACTICE & STREET ADDRESS (Do not provide a Post Office Box address)	
OFFICE TELEPHONE ( ) –	FACSIMILE TELEPHONE ( ) –
APPROXIMATE DATES OF CONSULTATION MM/DD/YYY FROM TO	COMMENTS, IF ANY
(2) NAME OF OTHER CARE PROVIDER TO INSURED	SPECIALTY, IF ANY, OF ATTENDING CARE PROVIDER
NAME OF FACILITY OR PRACTICE & STREET ADDRESS (Do not provide a Post Office Box address)	
OFFICE TELEPHONE ( ) –	FACSIMILE TELEPHONE ( ) –
APPROXIMATE DATES OF CONSULTATION MM/DD/YYYY FROM TO	COMMENTS, IF ANY

INFORMATION REGARDING THE CURRENT HEALTH STATUS OF THE INSURED

Provide a brief summary of the Insured's medical history and/or primary diagnosis, including known diagnosis dates.

If the policyowner is an entity, please include underlying documentation (i.e., trust agreement, corporate resolution, etc.).

NAME OF PREPARER: ______________________

SIGNATURE of PREPARER: ______________________ DATE: ______________

1979 Lakeside Parkway, Second Floor Atlanta, Georgia 30084 p: 1.800.252.5282 f: 1.770.724.7373 www.thelifeline.com

This is not an advertisement. This is not intended for use or distribution to potential policyowners or insureds.

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