Documents Package Prepared for: **The Brokers Network**

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Document Name	Description	Expiration Date
RHA - Life Forms	The Brokers Network life new business forms	12/31/2199
LAA1297	Request for Life Insurance Interview	11/7/2040

The Brokers Network Life Insurance Application Transmittal

☎ 407.898.5521 / 800.749.9900 🖷 407.896.0924 💻 www.thebrokersnetwork.com

Proposed Insured: _____

Agent: _____

Submit application package to:
The Brokers Network
2300 North Orange Avenue
Orlando, FL 32804

Did you order the Medical Requirements? ☐ No ☐ Yes Service: _____

☐ Do not use the MedPort process with the Part II being completed over the telephone. This only applies to traditional life applications for Banner, ING, John Hancock and Nationwide where The Brokers Network orders the exam.

Quoted Modal Premium: _____ Mode: _____

Rate Class: ☐ Preferred Best ☐ Preferred ☐ Standard Plus ☐ Standard ☐ Rated

Nicotine Usage: ☐ None ☐ Cigarettes ☐ Cigars ☐ Pipe/Chew ☐ Patch/Gum

Preliminary Medical Information:

Height: _____ Weight: _____

Is the Proposed Insured taking medication to control: ☐ Hypertension ☐ Cholesterol

Has a parent or sibling ever been diagnosed or died from any of the following:

Condition	Family Member	Age at Diagnosis	Age at Death
Cancer			
Cardiovascular			
Coronary Artery Disease			
Cerebrovascular Disease			
Diabetes			

Purpose of Insurance:

Personal: ☐ Family Needs ☐ Estate Planning ☐ Other _____

Business: ☐ Buy/Sell ☐ Keyperson ☐ Debt Recovery

The following is for all cash value products only:

Is there a 1035 Exchange? ☐ No ☐ Yes Amount: _____

A signed illustration with ALL numbered pages is required at submission for all cash value products.

Rex Huffman & Associates, Inc.

2300 North Orange Avenue
Orlando, Florida 32804

Phone 407.898.5521
Fax 407.896.0924

HIPAA Authorization to Release Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Rex Huffman & Associates, Inc. (dba The Brokers Network) and its affiliated agencies, including but not limited to RSA Medical, to disclose my personal financial and health information to the insurance companies listed below.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning me to my Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, my prescription records and history of medication prescribed but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to Rex Huffman & Associates, Inc. (dba The Brokers Network), including but not limited to RSA Medical. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed below and their re-insurers as well as Rex Huffman & Associates, Inc. (dba The Brokers Network) and its staff, employees and affiliated companies.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to my Representative to revoke this authorization and that the revocation will take effect when my Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I understand that if I refuse to sign this authorization, Rex Huffman & Associates, Inc. (dba The Brokers Network) may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization.

_____	_____
Proposed Insured's Name	Agent's Name
_____	_____
Proposed Insured's Signature	Agent's Signature
_____	_____
Date	City and State

Allianz Life Insurance Company of North America, American General Life Insurance Company, American National Insurance Companies, Aviva Life & Annuity Company, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Companion Life Insurance Company, Genworth Financial Family of Companies, John Hancock, Lincoln Benefit Life, Lincoln National Life Insurance Company, Metropolitan Life Insurance Company and MetLife Investors USA Insurance Company and their affiliates, Mutual of Omaha, National Life Group, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, North American Company for Life & Health, Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life Insurance Company, Protective Life and Annuity Insurance Company of NY, Prudential Insurance Company of America, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Savings Bank Life Insurance Company of Massachusetts, Security Life of Denver Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, United States Life Insurance Company in the City of New York, William Penn Life Insurance Company of New York, Zurich American Life Insurance Company.

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Employer-Owned Life Insurance Notice and Consent

The following is a brief summary of the rules that apply to Employer-Owned Life Insurance polices, including buy-sell funding. These rules generally apply to contracts issued on August 18, 2006 or later. These rules also apply to policies issued before August 18th ("grandfathered policies") that undergo material increases in the death benefit or other material changes. Due to the complexity of the new rules, it is not entirely clear how they might apply in certain settings where an employer is not directly the owner or beneficiary of the policy. For example, when life insurance is acquired to fund a cross-purchase buy sell arrangement. In these situations it appears to be prudent to comply with the requirements of the law. While these instructions refer to the "employer" and "employee," the actual Form has been designed for use in both direct employer-owned and indirect employer-owned situations. This summary is not meant to be comprehensive or to cover every situation and should not be construed as tax or legal advice. You should consult with and rely on the advice of your own tax counsel.

As explained below, if "Notice and Consent" are received and certain Specified Exceptions are met, the death benefit of a life insurance policy owned by and payable to an employer on the life of an employee, will, generally, remain income tax-free. ***IF THESE RULES ARE NOT SATISFIED, THE DEATH BENEFIT WILL GENERALLY BE TAXABLE.***

I. "Notice and Consent"

The "Notice and Consent" requirements are satisfied if ***before*** the policy is issued or ***before*** there is a material increase or other material change to a grandfathered policy:

1. The employee is notified in writing that the employer intends to insure the employee's life,

2. The employee is notified in writing of the maximum face amount for which the employee could be insured at the time the policy was issued.

3. The employee provides written consent to being insured under the policy and that such coverage may continue after the insured terminates employment, and

4. The employee is informed in writing that the employer will be a beneficiary of any insurance proceeds payable on the death of the employee.

II. Specified Exceptions

In general, if the notice and consent requirements are satisfied, policy death proceeds may be received income tax free (subject to existing Transfer for Value and Alternative Minimum Tax rules) if any of the following exceptions are met:

1. **Recent Employees:** The insured was an employee at any time during the 12-month period before death. (In other words, if the employee is no longer employed by the employer at the time of death, the death proceeds will keep their income tax-free status if death occurs within the 12 months following the date of the employee's employment termination.)

2. **Directors and Highly Compensated Employees**: If at the time of the policy was issued, the insured was:
    a. a director
    b. a highly compensated employee under the rules for qualified retirement plans:
        (a) generally, owner of more than 5% of outstanding or voting stock of the employer (or more than 5% of capital or profits interest if employer is not a corporation) in the current or preceding year; or
        (b) an employee receiving compensation as follows: for policies issued in 2006, employee earned in excess of $100,000 in 2005; for policies issued in 2007, employee earned in excess of $100,000 in 2006, or
    c. a highly compensated individual under the rules for self-insured medical reimbursement plans, looking at the highest paid 35% of employees (i.e., generally one of the five highest paid officers, or among the highest paid 35% of all employees, or a more than 10% owner by value of employer stock.)

3. **Death Benefits Paid to Heirs**: To the extent that death proceeds paid in the taxable year are received:
    (a) by a family member of the insured,
    (b) by an individual who is the designated beneficiary of the insured (other than the employer),
    (c) by a trust established for the benefit of any such family member or designated beneficiary, or
    (d) by the estate of the insured.

4. **Buy/Sell Situations**: To the extent that death proceeds are used in the taxable year they are received to purchase an equity (or partnership capital or profits interest) in the employer from a family member, beneficiary, trust or estate.

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Employer-Owned Life Insurance Notice and Consent

Employee/Proposed Insured Information

Name: _____

Social Security #: _____ Date of Birth: _____

Employer/Policyowner Information

Company Name: _____

Tax ID #: _____ Address: _____

Notice by Employer/Policyowner

- Employer intends to apply for insurance on the life of the Employee (Proposed Insured).
- The maximum face amount the Employee/Proposed Insured could be insured for at the time the contract is issued is $_____.
- The Employer will be the Policyowner of any policy issued and a beneficiary of any proceeds payable upon the Employee/Proposed Insured's death.

Consent of Employee/Proposed Insured

- I consent to being an insured under the insurance policy for which my Employer intends to apply.
- I consent to my Employer continuing coverage, after my employment ends, under any policy issued.
- I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

Acknowledgement

This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting services. By providing this form, Rex Huffman & Associates, Inc. makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the employer unless notice-and-consent requirements specified in the law are fulfilled. Rex Huffman & Associates, Inc. and its affiliated agencies do not provide tax or legal advice. We did not create this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation. A photocopy of this form shall be as valid as the original.

Employee Signature: _____ Date: _____

Employer Signature: _____ Title: _____

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The Contracting Warehouse

We no longer offer paper contracting kits for the majority of our carriers. Instead, we now offer the **Contracting Warehouse**, your virtual contracting assistant. All your pertinent information (your profile) will be safely stored in the Contracting Warehouse to make your new appointments with our carriers a point and click process.

All your information is stored on multi-level secured servers and will only be accessible by you. Neither The Brokers Network nor any of our third-party vendors will have access to your stored data in the **Contracting Warehouse**. The stored data is your private information and will remain such.

First time users will need to create their profile in the **Contracting Warehouse**. You will be asked questions regarding your personal information, addresses, business information, employment history, carrier affiliations, license information, errors and omissions coverage, legal information, direct deposit information and some additional specific information required by our carriers. The entire process should take about 15-20 minutes. Once your profile is completed, you are never more than about 60 seconds away from completing contracting with one of our participating carriers!

Participating companies are as follows:

Allianz Life
Allianz Life of NY
American Equity
American General
American National
American National of NY
Athene Annuity & Life
Aviva Life & Annuity
AXA Equitable Life
Banner Life
Companion Life of NY
Fidelity & Guaranty
Fidelity & Guaranty of NY
Fidelity Life
Foresters
Forethought Life
Genworth Life
Genworth Life & Annuity
Genworth Life of NY
Great American
Illinois Mutual
ING ReliaStar Life
ING ReliaStar Life of NY
ING Security Life of Denver
ING USA Annuity & Life
Integrity Life
John Hancock Life
John Hancock Life of NY
John Hancock Life USA
Legacy Marketing Group
Life of the Southwest
Lincoln Benefit Life
Lincoln National Life
MetLife Investors USA
Metropolitan Life
Minnesota Life
Mutual of Omaha
National Life
Nationwide Life & Annuity
North American Company
Peterson Int'l Underwriters
Phoenix Companies
Principal Financial
Prudential Financial
Reliance Standard
Savings Bank Life of Mass
Standard Insurance
Symetra Life
Transamerica Financial
Transamerica Life
United Home Life
United of Omaha
United States Life of NY
United World
William Penn of NY
Zurich American

To get started, log in to our website at **www.thebrokersnetwork.com** and then click on the **Contracting Warehouse** link found in lower right hand corner of our welcome page. If you are not sure what your login codes are or are not yet a member of the Brokers Network, please contact Leon Huffman at ext. 129 for assistance.

Please direct any questions to Leon Huffman
407-898-5521 or 800-749-9900, ext. 129

Banner Life Insurance Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
(800) 638-8428

Date of Request:_____

Request for Life Insurance Interview

*** ALL FIELDS MANDATORY**

PROPOSED INSURED

_____ (First Name, Middle, Last Name)

XXX-XX-_____ (Last 4 digits S.S.#)

Date of Birth _____/_____/_____ (Month) (Day) (Year)

RISK EVALUATION

	If answer to question is not known, please leave blank. Criteria Questions			Check One Classification For Each Question
		If No...	**If Yes...**	
1	1a. Do you have a history of alcohol or substance (drug) abuse?	Check P+ and go to question 2.	Go to question 1b.	P+ P S
	1b. Has there been any abuse in the past 10 years?	Check P and go to question 2.	Check S and go to question 2.	
		If No...	**If Yes...**	
2	Have you had any DUIs in the past 2a. 5 years?	Check P+ and go to question 3.	Go to question 2b.	P+ S+ S
	2b. 3 years?	Check S+ and go to question 3.	Check S and go to question 3.	
		If No...	**If Yes...**	
3	Have you had more than two motor vehicle moving violations in the past three years?	Check P+ and go to question 4.	Check S+ and go to question 4.	P+ S+
		If No...	**If Yes...**	
4	4a. Has either parent or a sibling had a history of cardiovascular disease before age 60?	Check P+ and go to question 5.	Go to question 4b.	P+ P S+ S
	4b. Has either parent died as a result of cardiovascular disease before age 60?	Check P and go to question 5.	Go to question 4c.	
	4c. Have both parents died as a result of cardiovascular disease before age 60?	Check S+ and go to question 5.	Check S and go to question 5.	
5	What is your height? _____ weight? _____ Based on height and weight, select the underwriting classification according to the build chart below. If weight meets or exceeds limit for standard (S) class, check S.			P+ P S+ S
		If No...	**If Yes...**	
6	Have you used any nicotine-based products in the past 6a. 36 months?	Check P+ and go to question 7.	Go to question 6b.	P+ P S+ PT ST
	6b. 24 months?	Check P and go to question 7.	Go to question 6c.	
	6c. 12 months?	Check S+ and go to question 7.	Check PT if answers from 1 to 5 are all P/P+, otherwise, check ST.	
7	**What is the lowest (on a scale where P+ is highest) underwriting class checked in any of the answers to questions 1-6?**		**Check one box.**	**P+ P S+ S PT ST**

This questionnaire is designed to provide a tentative premium classification based on a portion of the criteria used to determine a final premium classification. Final approval, classification, and actual rates will be subject to and based upon the entire underwriting process, your medical history, information developed during your interview with the Banner Call Center representative and/or any specific underwriting requirements and criteria. Please refer to the policy form for full disclosure of benefits and limitations. Forms and policy provisions may vary by state. Not available in all states.

Legend	
P+	Preferred Plus
P	Preferred
S+	Standard Plus
S	Standard
PT	Preferred Tobacco
ST	Standard Tobacco

Build Chart

Height	P+		P	S+	S	Height	P+		P	S+	S
	Male	Female	Male/ Female	Male/ Female	Male/ Female		Male	Female	Male/ Female	Male/ Female	Male/ Female
5'0"	144	135	158	166	172	6'0"	207	180	228	240	249
5'1"	148	138	163	172	178	6'1"	213	184	234	245	255
5'2"	153	140	168	175	183	6'2"	219	188	241	253	263
5'3"	158	143	174	182	190	6'3"	225	193	247	259	269
5'4"	163	145	179	188	195	6'4"	230	197	253	265	276
5'5"	168	148	185	194	202	6'5"	237	201	260	272	283
5'6"	174	150	191	200	208	6'6"	243	205	267	280	291
5'7"	179	155	197	206	215	6'7"	249	209	274	287	299
5'8"	185	160	203	212	221	6'8"	256	214	281	294	306
5'9"	190	165	209	219	228	6'9"	262	218	288	302	314
5'10"	196	170	215	226	234	6'10"	268	222	295	309	322
5'11"	201	175	221	231	241	6'11"	276	226	303	317	330

Proposed Insured _____

PROPOSED INSURED INFORMATION

Quoted Premium $ _____ Face Amount $ _____

Product (Please check only one.)

OPTerm ☐ 10 ☐ 15 ☐ 20 ☐ 30

Term Rider ☐ 10 ☐ 15 ☐ 20

Life Value Term ☐ 20 ☐ 30

Life Choice UL ☐ Life Step UL ☐ (<100K only)

Other ☐ _____

Payment method ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)

Frequency of premium payment ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT Only)

Gender ☐ Male ☐ Female

Is this prospective policy to replace existing insurance? ☐ Yes ☐ No

What is the purpose of this insurance? ☐ Buy/Sell ☐ Keyman ☐ Family Protection ☐ Income Replacement

☐ Other _____

Policy Owner (if other than Proposed Insured) Name _____

City, State _____ Zip _____

Date to Save Age ☐ Yes ☐ No

Waiver of Premium ☐ Yes ☐ No

TIAA - If your client is eligible, would you like us to offer temporary insurance coverage? ☐ Yes ☐ No

Exam Provider ☐ APPS ☐ EMSI ☐ ExamOne ☐ Portamedic ☐ Superior Mobile Medics

(Available Interview Hours: Monday - Friday, 9:00 a.m. to 10:30 p.m. ET)

Please contact me: Date _____ (MM/DD/YY) Local time: _____ ☐ AM ☐ PM

The Banner Life Call Center will contact you within two hours of the designated time.

PrimaryTelephone No. _____ ☐ Home ☐ Work ☐ Cell

Secondary Telephone No. _____ ☐ Home ☐ Work ☐ Cell

Address _____ (Please Print)

City _____ (Please Print) State _____ (Please Print) Zip Code _____

E-Mail Address _____ (Please Print)

Remarks:

AGENT INFORMATION

I hereby authorize the Company to affix my electronic signature to all life insurance applications and related forms submitted by the undersigned. I will immediately notify the Company should this authorization for use of this signature or any prior signature authorization be terminated or revoked in any jurisdiction.

X _____ Signature of Agent _____ Date Signed

Agent Name _____ Agent # _____ S.S. # _____ - _____ - _____

Telephone # _____ Share of Commission _____

Additional Agent

Agent Name _____ Agent # _____ S.S. # _____ - _____ - _____

Telephone # _____ Share of Commission _____

Brokerage General Agent (BGA) _____ BGA Number _____

Case Manager _____ **Case Manager E-Mail Address** _____

DISCLAIMER

This is not an application for life insurance coverage. Signing or completing this form will in no way serve to create or commence life insurance coverage. Signing or completing this form does **NOT** mean that coverage is effective.

Please send the completed form to 3275 Bennett Creek Avenue, Frederick, MD 21704, fax to 301-294-6960 or email to Banner-Submit@lgamerica.com.