First Protective

toll free 800.876.3950
web www.firstprotective.com

DROP TICKET CHECKLIST

Insured's Information

Full Name: _____ Gender: M☐ F☐ Save age: Y☐ N☐
Email Address: _____
DOB: _____ DL#:_____ State: _____ SSN: _____ State of Birth: _____
Best Phone # to Call: _____ Alternate #:_____
Best Time To Call For Interview: _____ Time Zone: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Occupation: _____
Tobacco Use: Yes☐ No☐ If yes, date of last use and type used: _____
Height: _____ Weight: _____ Gain/loss in last year: _____

Coverage Applied For

(Agent will complete this)

Plan Name: _____ Term Length: _____
Face Amount: _____ Premium Quoted: _____ Billing Frequency: _____ Riders:_____
Purpose of coverage: Personal☐ Business☐ Bind Coverage: Yes☐ No☐
Rating Class Applying For: Pref Best☐ Pref☐ Std Plus NS☐ Std NS☐ Pref Tobacco☐ Std Tobacco☐
If rating class is unknown, see attached Underwriting Pre-Qualification Questionnaire attached to assist
Source of premium funds: Current Income _____ Loans/financing _____ Existing policies_____

Income Information

Annual Income: _____ Unearned Income: _____ Net Worth: _____
Total Household Income: _____

First Protective

toll free 800.876.3950
web www.firstprotective.com

Owner Information

Owner (if other than insured):_____
Relationship to proposed insured: _____
DOB: _____ Gender: M ☐ F ☐ SSN: _____ State of Birth: _____
Owner Email Address:_____
Phone#:_____ Mobile#:_____ Office #:_____
Street Address: _____
City: _____ State: _____ Zip Code: _____

Primary Beneficiary Information

Will the beneficiary be the same as owner? Yes ☐ No ☐ *If No, complete this section.*
Full Name: _____ DOB: _____SSN:_____
Relationship to Insured: _____ Percentage of Share: _____
Full Name: _____ DOB: _____SSN:_____
Relationship to Insured: _____ Percentage of Share: _____
Full Name: _____ DOB: _____SSN:_____
Relationship to Insured: _____ Percentage of Share: _____

Contingent (Optional) Beneficiary Information

Full Name: _____ DOB: _____SSN:_____
Relationship to Insured: _____ Percentage of Share: _____

Existing/Pending Coverage

Carrier Name	Policy #	Death Benefit Amt.	Type		
			Term ☐ Perm ☐	Inforce ☐ Pending ☐	Replacing? ☐ Yes ☐ No
			Term ☐ Perm ☐	Inforce ☐ Pending ☐	Replacing? ☐ Yes ☐ No
			Term ☐ Perm ☐	Inforce ☐ Pending ☐	Replacing? ☐ Yes ☐ No

Reason for replacement: _____

If replacement is involved, the above in-force policy information is REQUIRED to be completed.

Agent Name: _____ Email Address: _____ Phone: _____