The 1-Page Term Intake Form

Upon completion email this form to your AimcoR Enterprise Insurance Group (EIG) Regional Office. If you have questions or require assistance completing this form please contact your AimcoR EIG regional office. To find out who your regional office is; contact (866) 428-0108 or visit www.aimcoreig.com

Advisor Information:

Advisor Name:	Advisor Phone:	Broker/Dealer Affiliation:
Advisor Email:	Date This Intake Form Was Completed:	

Client Information: All Fields Are Required

Insured Name:				
State of Residence	DOB:	Gender:	Marital Status:	Client Birth Country / State:
Social Security #:	Address:			
City:	State:	Zip:	Primary Phone:	
Driver's License State:	Driver's License #:		Driver's Licenses Exp. Date:	
Client Email Address:			Best Time to Contact Client: ☐ AM ☐ PM	

Tobacco Usage: ☐ Y ☐ N (if yes, indicate type of tobacco and last date of use):

Has the proposed insured ever been treated for the following? Cancer, Heart Disease, Stroke (if yes, indicate date of diagnosis) ☐ Yes ☐ No

Rate Class, Carrier & Product Information

Rate Class:	Type of Insurance: (Term Length):	Face Amount:
Carrier:	Product Name:	
Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT)		Premium Amount: $

Employment and Income Information

Is the Proposed Insured Currently Employed? ☐ Yes ☐ No		Employer:	Job Title:
Annual Income:	Estimated Total Assets:	Estimated Total Liabilities:	Net Worth:

Owner and Beneficiary Information

If Insured is Not Owner (Please complete): Owner is a ☐ Person ☐ Trust ☐ Corporation ☐ Other

Owner Information: (Name, Relationship, Address - City, State, Zip)

Primary Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %
Primary / Contingent Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %
Contingent Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %

Replacement Information

Does the client currently own any life insurance? ☐ Yes ☐ No | If Yes, Is this Policy Replacing any existing coverage? ☐ Yes ☐ No

If Client Has Existing Coverage, Provide Insurance Company(s) and Policy Number(s):

If Yes, Indicate Reason for Replacement:

What is the purpose of this insurance?: (i.e. income replacement, etc.)

Additional Information

Rider(s): ☐ Waiver of Premium ☐ Other (Please specify) : | Source of funds for premiums?

Has the client ever been declined, rated or postponed for life or health insurance? ☐ Yes ☐ No | How long have you known insured?

Did you meet with the client personally to complete this form? ☐ Yes ☐ No | Was an illustration presented to the insured? ☐ Y ☐ N

Advisor Remarks: