



Check
Appropriate
Company

Final Expense
Pre-Qualifying Worksheet

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Complete this worksheet in order to collect important applicant information BEFORE you call DIMA. Once you complete this form, please call 800-604-6844 for the application and underwriting completion process. Agent, Insured, (Owner and/or Payor, if different) must be on the phone at the time of the call. This worksheet contains sensitive information and should be kept secured for your records or destroyed. DO NOT SEND IN THIS FORM.

Agent: \_\_\_\_\_ Agent Number \_\_\_\_\_ Date: \_\_\_\_\_
POSTI Reference #: \_\_\_\_\_ Issue State: \_\_\_\_\_ Telesales application [ ] YES [ ] NO

THE HIGHLIGHTED INFORMATION IS NECESSARY TO INITIATE UNDERWRITING:

Proposed Insured Full Name: \_\_\_\_\_
Date of Birth \_\_\_\_\_ Present Age \_\_\_\_\_
Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_
State of Birth \_\_\_\_\_ Country of Birth \_\_\_\_\_
Social Security No. or ITIN \_\_\_\_\_
Face Amount \$ \_\_\_\_\_
Have you used tobacco, nicotine, or e-cigarettes in any form in the past 12 months? [ ] YES [ ] NO
\*\*\*\*\*
Street Address \_\_\_\_\_
City, State, Zip \_\_\_\_\_
Home/Cell Phone \_\_\_\_\_
Work Phone \_\_\_\_\_

Plan Approved For:
[ ] SIMPL Preferred [ ] SIMPL Standard. [ ] MWL
Premium Amount \$ \_\_\_\_\_
Amount paid with application \$ \_\_\_\_\_
Premium Mode:
[ ] Monthly Bank Draft OR [ ] Direct Express Card
[ ] Quarterly [ ] Semi-Annual
[ ] Annual

OWNER of Policy (if other than Proposed Insured)
Relationship \_\_\_\_\_
Social Security No. \_\_\_\_\_
Address \_\_\_\_\_
Home/Cell Phone \_\_\_\_\_

Bank Information: Name of Financial Institution \_\_\_\_\_
Routing #: \_\_\_\_\_
Account #: \_\_\_\_\_
Draft Date: \_\_\_\_\_
[ ] Check here to draft first premium

Primary Beneficiary \_\_\_\_\_
Relationship \_\_\_\_\_
Home/Cell Phone \_\_\_\_\_
Contingent Beneficiary \_\_\_\_\_
Relationship \_\_\_\_\_
Home/Cell Phone \_\_\_\_\_

OR

DIRECT EXPRESS CARD: BENEFIT PAYMENT RESET DATE OF:
[ ] 1st of month [ ] 3rd of month [ ] 2nd Wednesday [ ] 3rd Wednesday [ ] 4th Wednesday
Direct Express Card Acct. # \_\_\_\_\_ Exp. Date: \_\_\_\_\_
Name as it Appears on Card: \_\_\_\_\_

**Replacement Information: (Replacement not allowed for tele-sales)**

YES NO

1. Does proposed Insured have existing life insurance policies or annuity contracts? .....
2. Will this insurance replace or change any other insurance policies or annuity contracts? .....
- If "Yes" to either question, please provide details of the insurance, including Amount, Company & Plan of Insurance and appropriate Replacement Form, if required: \_\_\_\_\_

**Use the following health questions to decide which Final Expense plan to offer****If the applicant answers "Yes" to any question in Part 1, DO NOT PROCEED with the application.****Part 1**

YES NO

Have you ever been diagnosed have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

1. Congestive heart failure (CHF), cardiomyopathy, memory loss, Alzheimer's, senile dementia, dementia, heart defibrillator implant, two or more instances of internal cancer(s) or terminal illness? .....
2. Organ transplant (other than corneal), untreated Hepatitis C, kidney failure or dialysis, amputation due to diabetic complications, multiple sclerosis, muscular dystrophy, mental retardation, amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease, Down's syndrome, cystic fibrosis or Huntington's disease? .....
3. Diabetes at age 9 or younger? .....
4. AIDS, AIDS Related Complex, tested positive for HIV virus or any other disorder of the immune system? .....

Within last 2 years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

5. Uncontrolled diabetes or uncontrolled high blood pressure? .....

Within the last year have you:

6. Been confined to a hospital, been advised to have surgery or hospitalization, used oxygen due to a medical condition, been unable to care for yourself or been bedridden at home or in a nursing home, hospice, long-term care or assisted living facility?  
Definition of assisted living: requires help in at least one area of skills considered necessary for living and caring for oneself (feeding, dressing or bathing) .....

**If all "No" answers in Part 1, complete Part 2.****Part 2 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.**

YES NO

Within the past 2 years have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- (a) Angina (chest pain), any type of heart or circulatory surgery, heart attack, or received a pacemaker or stent? .....
- (b) Stroke, Transient Ischemic Attack (TIA/mini-stroke) or paralysis? .....
- (c) Cancer or received or been advised to receive chemotherapy or radiation for cancer (the term "cancer" includes melanoma, but excludes basal cell skin cancer)? .....
- (d) Aneurysm, brain tumor or sickle cell anemia? .....
- (e) Complications of diabetes such as nephropathy (kidney), neuropathy (nerve, circulatory), retinopathy (eye) diabetic coma or insulin shock? .....
- (f) Alcohol or drug abuse, have you used illegal drugs or been convicted of felony or on parole? .....
- (g) Used a walker, wheelchair or electric scooter due to chronic illness or disease? .....

**If all "No" answers in Part 2, complete Part 3. Otherwise, select MWL & check for state availability.****Part 3 Complete all questions and circle the condition(s) to which each "Yes" answer, if any, applies.**

YES NO

Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- (a) Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, emphysema, peripheral vascular disease or peripheral artery disease? .....
- (b) Chronic hepatitis, Hepatitis C, cirrhosis of the liver, chronic pancreatitis, liver disease or kidney disease? .....
- (c) Insulin use before age 25? .....
- (d) Irregular heartbeat, atrial fibrillation, Systemic Lupus (SLE), epileptic seizures, Parkinson's disease? .....

**If all "No" answers in Part 3, select SIMPL Preferred. Otherwise, select SIMPL Standard.****AGENT NOTES:**