Trinity/Family Benefit Quick Reference Tips

TAKES DIRECT EXPRESS CARD

PH Interview # 888-995-7722

Age range: 50-85

Have DRAFT DATE & FACE AMOUNT ready for phone interview

Min Face amount: $2,500

Max Face Amount: $25,000

Filling Out Application

Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes.
Always make a duplicate copy of file ***BEFORE*** filling out application with client info
Retitle file with clients first and last name
Fill out yellow highlighted boxes with client info
There are a number of items that need to be filled out in section 5 but the space is very small be sure to double check and make sure all highlighted areas are filled out
Section 6 details only needed if there is a "yes" to both existing insurance and replacement. If there is a "yes" to existing insurance the replacement form needs to be filled out. Additional info on existing insurance on replacement page only needs to be filled out if a replacement is occurring.
There are two sections where it asks for banking info. Only one needs to be filled out. If not doing Social Security Billing you can delete that page.
If client is on social security billing don't let the client talk you out of picking their social security deposit date.

How to Quote with Cardinal Quoting App

Underwriting Type: Full
Product Type: Level

Trinity Life Insurance Company

Golden Eagle

Premium:	$41.28/mo*
Face Value:	$10,000.00
Annual Fee:	$30.00

Family Benefit Life Insurance Co…

Golden Eagle

Premium:	$41.28/mo*
Face Value:	$10,000.00
Annual Fee:	$30.00

Prep Client for Phone Interview

1. Read out all questions to applicant prior to phone interview to make sure there are no surprises and let them know that the interviewer will ask these exact same questions.
2. Explain that you will take a few minutes to give the interviewer all the basic information and that they will then want to speak with client.
3. Prep client that the conversation will be recorded and will need to give authorization for MIB and confirm that agent told them about HIPAA statement.
4. If there is another person in the room explain that only the client can answer
5. Once Interviewer has read the **entire** question the client can give a "no" response. **Tell client not to offer explanations**
6. If there are any questions that could relate to their condition explain to them that they need to say "no" i.e. "Mrs Metformin you need to say "no" to the insulin question because you started taking it AFTER age 40. Or if they had a heart attack be sure to explain to them that they need to say no because the heart attack was over 24 months ago
7. Prep client that after all the questions are asked they will be able to see all the medications that you have been prescribed in the last 7 years and may ask you about a few of them, even the ones they no longer take.

Prep client for what questions they may ask and what answers to give.
Drugs frequently asked about.. you may even want to specifically ask the client if they've ever taken any of the following
Gabapentin
Inhalers
Water Pills (furosemide, lasik, hctz)
Clopidgrel, Warferin, Coumadin, Metoprolol, Plavix, Nitros
If they have been prescribed inhalers they will ask them what its for, how often they fill it, and how frequently they use it.
If necessary use the mute function on your phone to tell your client how to answer question.

How to Submit App

Delete instruction page and any other page unnecessary before submitting. I.e. height/weight, replacement, social security bill page before submitting

Go to Trinity website - https://trinity.ihlic.com/member/login
Click on "Document Upload"
Click "Upload"
Select "New Business / Underwriting"
Click "Add Files"———"Browse"———"Dropbox"———The Application
Click "Start Upload"

or

Fax: 262.289.3224 (The pdf)

or

Cardinal Senior Benefits Submission Link

www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

Height		Weight		
Feet	Inches	Minimum	Maximum Simplified	Maximum Graded
4	9	78	197	218
4	10	78	206	227
4	11	81	213	236
5	0	84	222	245
5	1	86	229	253
5	2	90	237	262
5	3	93	246	272
5	4	96	253	279
5	5	98	260	287
5	6	101	268	296
5	7	104	275	304
5	8	107	284	314
5	9	110	292	323
5	10	113	299	331
5	11	116	308	340
6	0	120	316	348
6	1	124	325	357
6	2	127	333	365
6	3	131	342	374
6	4	134	350	381
6	5	137	357	388
6	6	141	367	397
6	7	145	375	406
6	8	148	383	413

Application for Individual Life Insurance (Please Print, use black or blue ink)

Family Benefit Life Insurance Company (FBLIC), 7633 East 63rd Place, Suite 230, Tulsa, Oklahoma 74133

Telephone Interview Completed: ❒ Yes ❒ No
[(888) 995-7722] Order #_____

1. Full Name of Proposed Insured: First _____ MI _____ Last _____
Sex:_____ Date of Birth:_____/_____/_____ State of Birth:_____ Age:_____ SSN:_____-_____-_____ Marital Status: _____
Residence Address: _____
Street City State Zip Code
Home Phone:_____ Work Phone:_____ E-Mail:_____

2. Owner: Name_____ SSN or TIN: _____-_____-_____ Phone:_____
Address_____ Relationship:_____

3. Send Premium Notices to: ❒ Insured ❒ Owner ❒ Other (If Other) Name:_____
Address:_____ Relationship:_____
Street City State Zip

4. Beneficiaries:
Primary_____ Relationship_____ Date of Birth_____ SS#_____
Contingent_____Relationship_____ Date of Birth_____ SS#_____

5. Plan Applied For: ❒ Simplified ❒ Graded ❒ Non-Tobacco ❒ Tobacco APL: ❒ Yes ❒ No ❒ Annual ❒ Semi-Annual ❒ Quarterly ❒ Monthly EFT
Face Amount: $_____ Modal Premium: $_____ Premium Collected: $_____ ❒ None – Draft First Premium
If Monthly, Draft Date ___/____/___ (1st – 28th) or ❒ 2nd Wed. ❒ 3rd Wed. ❒ 4th Wed. Requested Effective Month_____ Yr_____

6. Does the Proposed Insured and/or Owner have any existing life insurance or annuity coverage? ❒ Yes ❒ No
Will any existing insurance or annuity policy with another company be discontinued or changed if the insurance applied for is issued? ❒ Yes ❒ No
(If yes, give details.) Company: _____ Policy #: _____ Coverage Amount: _____ Year Issued_____

7. Has any other life insurance company declined to issue, reinstate or renew, rated, modified, postponed, or cancelled any life insurance on the Proposed Insured? ❒ Yes ❒ No (If yes, provide details in remarks section below.)

8. Is the Proposed Insured a United States citizen? ❒ Yes ❒ No Is the Owner a United States citizen? ❒ Yes ❒ No

9. Proposed Insured's Height _____ Weight _____ In the Past year any ❒ gain ❒ loss _____ lbs.

10. Have you used tobacco or nicotine products in any form in the past 12 months? ❒ Yes ❒ No

11. Have you ever received or been given medical advice by a medical professional you need to receive an organ or tissue transplant? ❒ Yes ❒ No

12. Have you been diagnosed or treated by a member of the medical profession as having: AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or HIV (Human Immunodeficiency Virus) virus? ❒ Yes ❒ No

13. Have you ever been diagnosed with congestive heart failure, cardiomyopathy or a life expectancy of 24 months or less? ❒ Yes ❒ No

14. Have you ever been diagnosed with, treated for or taken medication for: dementia, Alzheimer's disease, mental incapacity, Downs Syndrome, Huntington's disease, Lou Gehrig's Disease (ALS), cystic fibrosis, cerebral palsy, muscular dystrophy, or sickle cell anemia? ❒ Yes ❒ No

15. Are you currently, or within the past 6 months have you been: hospitalized, bedridden, used oxygen to assist in breathing, confined to a wheelchair, nursing home, hospice, received home health care or been on dialysis? ❒ Yes ❒ No

16. Within the past 12 months have you been diagnosed as having, or been hospitalized for: heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind to improve circulation to the heart or brain? ❒ Yes ❒ No

17. Within the past 12 months have you been: hospitalized two or more times, or been advised by a medical professional to have surgery, hospital confinement, or nursing facility confinement and have not done so? ❒ Yes ❒ No

18. Within the past 24 months have you been diagnosed as having, treated by a medical professional for or taken medication for: internal cancer, leukemia, or melanoma? ❒ Yes ❒ No

19. During the past 24 months have you been: advised by a medical professional to have any diagnostic testing recommended, except for an HIV test, which has not been completed, or for which the results have not yet been received, or had or been advised to have treatment or counseling for alcohol or drug abuse. ❒ Yes ❒ No

20. During the past 24 months have you been treated by a medical professional for insulin shock, diabetic coma, amputation caused by disease, or have you ever taken insulin shots prior to age 40? ❒ Yes ❒ No

If any answers to questions 11-20 are "YES", Proposed Insured is not eligible for any coverage.

21. During the past 24 months have you begun prescribed medication for, been hospitalized for, or been diagnosed as having: kidney insufficiency or failure, heart attack, stroke, transient ischemic attack (TIA), angina, aneurysm, or had cardiac or circulatory surgery of any kind to improve circulation to the heart or brain? ❒ Yes ❒ No

22. Have you ever been diagnosed as having: multiple sclerosis, epilepsy, Parkinson's, systemic lupus, cirrhosis of the liver, liver disease, liver failure, hepatitis B or C or lung impairments (including chronic obstructive pulmonary disease (COPD), chronic asthma, chronic bronchitis, emphysema or fibrosis)? ❒ Yes ❒ No

If any answers to questions 21 - 22 are "YES", Proposed Insured may qualify for Graded Death Benefit.

Please underline the specific impairment/disease for any question answered yes, specify question number and provide details below.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
Each of the undersigned declares that:

a. I understand that the information obtained by use of this authorization will be used to determine eligibility for insurance and/or for the Insurance Company to determine its obligations under the policy issued in connection with this application.
b. The Insurance Company, its reinsurers, insurance support organizations, consumer reporting agencies and their authorized entities may obtain data about my health, prescription medication history, and related information, mode of living (except as may be related directly or indirectly to sexual orientation), avocations, and any other medical or non-medical information.
c. I authorize any licensed physician, doctor, medical practitioner, medical or medically related facility, laboratory, Pharmacy Benefit Managers, the Veterans Administration, MIB, Inc., viatical settlement company, employer, consumer reporting agency, creditor, government agency, insurance or reinsurance company or any other organization, institution or person, that has any records or information about me to release such records or information to the Insurance Company and its reinsurers when this authorization or a copy of it is shown. All sources but the MIB, Inc. may give such records or information to agencies that the Insurance Company has hired to retrieve the information. The information as provided herein pursuant to the authorization will not be redisclosed unless authorized by you or otherwise required by law. Covered Entities, as defined by the Health Insurance Portability and Accountability Act of 1996, may not condition treatment, payment or enrollment on whether this Authorization is signed.
d. Any request by the Insurance Company for medical records is on my behalf; the information must be provided within any requirements imposed by applicable state statutes governing patient access to medical records.
e. Data about mental illness, alcoholism, sexually transmitted diseases and the use of drugs are to be included.
f. I authorize the Insurance Company or its reinsurers to disclose my personal health information to MIB, Inc. in the form of a brief coded report for participation in MIB's fraud prevention and protection program.
g. This authorization is good for 24 months after it is signed.
h. The Insurance Company may obtain an investigative consumer report ("inspection report") on me. ❒ Yes, I want to be interviewed if such a report is obtained.
i. I have read this authorization and know my authorized representative or I may request a copy of it. I may revoke this authorization by writing to the Insurance Company.

ACKNOWLEDGEMENTS: I have read the completed application. I am not currently taking and I am not under the influence of any medications or drugs that would affect my ability to fully understand and to fully and accurately complete this application. I agree that this application will be the basis for, and will become part of, the policy that is issued. The above representations are true to the best of my knowledge and belief. Any material misrepresentation or misstatement contained herein may render any policy issued as a result of this application void from its inception. I agree the policy shall not be in effect until it has been issued by Family Benefit Life Insurance Company ("the Company") and the initial premium has been paid I understand that the agent has no authority to approve the application, change the policy or waive any policy provisions. I understand no insurance will be effective until the date stated in the policy and all eligibility requirements are met. I understand that the USA Patriot Act requires all financial institutions, including insurance companies, to verify the identity of their customers. I am providing my name, address, date of birth and taxpayer identification number to allow verification of identity. I understand the verification process may include the use of third-party sources to verify the information provided. I acknowledge receipt of a copy of the Information Practices Notice, MIB Pre-Notice and Fair Credit Reporting Act Notice. ❒ Yes ❒ No

I also acknowledge that I paid the Agent $_____in initial premium in exchange for the Conditional Receipt attached to this application. ❒ Yes ❒ No
I also acknowledge receipt of the Accelerated Benefit Rider Summary and Disclosure Statement. ❒ Yes ❒ No

FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured:_____ Date:_____

Signature of Proposed Owner (if other than Insured):_____ Signed at:(City & State)_____

AGENT CERTIFICATION: I certify that I have asked the Proposed Insured all of the questions on this application and have accurately recorded them. I also certify that replacement of existing insurance ❒ is ❒ is not involved.
Is any agent a relative of the Proposed Insured? ❒ Yes ❒ No Relationship:_____Send Policy to: ❒ Agent ❒ Owner

Agent: _____ Agent Code:_____ Agent Signature:_____ %_____

Agent: _____ Agent Code:_____ Agent Signature:_____ %_____

AUTHORIZATION TO HONOR CHECKS AND EFTs DRAWN BY FAMILY BENEFIT LIFE INSURANCE COMPANY

As a convenience to me, I hereby request and authorize Family Benefit Life Insurance Company (FBLIC) to pay and charge to my account checks and electronic fund transfers (EFTs) drawn on my account by and payable to the order of FBLIC provided there are sufficient collected funds in my account to pay such checks and EFTs upon presentation. I agree that FBLIC's rights in respect to each check and EFT shall be the same as if it were a draft drawn on you and signed personally be me. This authority is to remain in effect until revoked by me in writing, and until FBLIC actually receives such notice. I agree that FBLIC shall be fully protected in honoring any such check or EFT.

I further agree that if any such check or EFT is dishonored, whether with or without cause and whether intentionally or inadvertently, FBLIC shall have no liability whatsoever even though such dishonor results in the forfeiture of insurance. Please print information below for bank account to be charged.

Depositors' Name as Shown on Bank Account:_____ ❒ Checking

Insured's Name if Different than Depositor:_____ ❒ Savings

Bank Name:_____ Bank Address_____

Routing Number:_____

Account Number:_____ Signature:_____ Date Signed:_____

PLEASE ATTACH A VOIDED CHECK TO THIS AUTHORIZATION. Signature(s) must be the same as on signature card at bank.

BANK INDEMNIFICATION AGREEMENT
To the bank addressed above: So that you may comply with your depositor's request Family Benefit Life Insurance Company (the Company) agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions taken pursuant to your agreement to honor any check or electronic fund transfer (EFT) executed by this Company for the purpose of payment of insurance premiums.
2. That in the event any such check or EFT is dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss.
3. To defend at our own cost and expense any such action brought against you by any depositor or other person because of your actions pursuant to this agreement.
4. To refund you any amount erroneously paid to this Company on such check or EFT if claim is made within one month of the date of the check.

This agreement has been authorized in a resolution adopted by the Company's Board of Directors.

Gregg Zahn, President

FAMILY BENEFIT LIFE INSURANCE COMPANY
ACCELERATED BENEFIT RIDER SUMMARY AND DISCLOSURE STATEMENT

NOTICE: Death benefits and cash surrender values will be reduced upon payment of an accelerated benefit. The accelerated benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration of benefits qualifies for favorable tax treatment, the benefits will be excluded from your income and not subject to federal taxation. However, accelerated benefit payments may be taxable by your state. Tax laws relating to accelerated benefits are complex. You should consult a qualified tax advisor for specific information. Receipt of an accelerated benefit payment may adversely affect your, your spouse's or your family's eligibility for medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance or other public assistance programs. You should consult with a qualified advisor and with social services agencies regarding how receipt of such payment may affect eligibility for such programs.

Premiums: There is no premium associated with this rider.

The Effect of an Acceleration of a Benefit: After payment of the accelerated death benefit, the death benefit of the policy will be reduced by the amount of accelerated death benefit. Any premium payments, cash values, and other obligations and benefits under this policy, excluding that for riders, will be reduced proportionately. Your request must be in written form satisfactory to us and delivered to our Home Office. A notice will be sent to You, and to any irrevocable beneficiary. The Notice will show the effect the advance payment will have on the Policy benefits and values when an advance payment is made under the rider. Upon payment of this benefit, a revised schedule will be furnished. The schedule will show the reduced death benefit, cash value and premium amounts.

Benefits: This Rider allows the Owner of the life insurance Policy to which this Rider is attached to receive a portion of the death benefit in advance if the Insured is:
1. Diagnosed as having a non-curable medical condition that, within reasonable medical certainty, will result in death in 12 months or less. OR
2. Permanent confinement to a qualified nursing home.

A qualified nursing home means a facility that is operated pursuant to law. It must be licensed by the state in which it is located. A qualified nursing home provides nursing care as its primary function.

The Company will require a physician's statement:
1. Certifying the Insured's life expectancy in the event of Terminal Illness. OR
2. Certifying the Insured's permanent confinement.

Maximum Accelerated Death Benefit: The sum of all accelerated benefit payments may not exceed the smaller of $25,000 or 100% of the death benefit. If less than 100% of the death benefit is accelerated, the remaining death benefit must be at least $10,000.

The Company will pay the Accelerated Benefit based upon the following:
1. The Elected Proceeds. AND
2. Assumed interest. AND
3. Any outstanding indebtedness to the policy. AND
4. An administrative fee, not to exceed $150.

Termination: The rider will terminate when:
1. You make a written request to terminate the rider. OR
2. 100% of the face amount of the policy has been accelerated. OR
3. The Policy terminates.

Acknowledgement: I (We), the undersigned, hereby acknowledge that I (we) have received the Disclosure Statement for this rider. It was furnished to me (us) prior to the signing of the application for life insurance.

_____ _____

Applicant Date Agent Date

FAMILY BENEFIT LIFE INSURANCE CO.

ADMINISTRATIVE OFFICE: PO BOX 5205 • FRANKFORT, KY 40602-5205
Phone: (866) 440-1357 • Fax: (502) 227-7205

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the agent, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on an existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ❑ YES ❑ NO.
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ❑YES ❑NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because: _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____ _____
Applicant's Printed Name Applicant's Signature Date

_____ _____ _____
Agent's Printed Name Agent's Signature Date

I do not want this notice read aloud to me. ____ (Applicants must initial only if they do not have the notice read aloud.)

☐ **Trinity Life Insurance Company**
☐ **Family Benefit Life Insurance Company**

Administrative Office:
PO Box 5205 Frankfort, KY 40602-5205
Phone: 866-440-1357 Fax: 502.875.7084

Social Security Benefit Billing Authorization Form
For Checking and Savings Accounts

AUTHORIZATION AND SIGNATURE

I hereby request and authorize any of the Companies named above to pay and charge to my account checks and electronic fund transfers (EFTs) drawn on my account by and payable to the order of the Company provided there are sufficient collected funds in my account to pay such checks and EFTs upon presentation. As a convenience to me, I wish for the life insurance premium payments to match my Social Security Benefit Deposit. I agree that the Company's rights in respect to each check and EFT shall be the same as if it were a draft drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until the Company actually receives such notice. I agree that the Company shall be fully protected in honoring any such check or EFT.

I further agree that if any such check or EFT is dishonored, whether with or without cause and whether intentionally or inadvertently, the Company shall have no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date:	Account Holder's name typed or printed EXACTLY as it appears on account	Account Holder's signature EXACTLY as it appears on account
_____	_____	_____

PREAUTHORIZED TRANSFER PLAN DATA

☐ **Apply to attached application** ☐ **Apply to existing policies listed below**

Insured's Name (First, Last) _____ _____
Existing Policy Numbers _____ _____ _____

PREMIUM PAYMENT INFORMATION

Please select date of Social Security Benefit Payment:	☐ 1st of month ☐ 3rd of month ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

BANK INFORMATION

Name of Bank: _____

Bank address: _____

COMPLETE THE FOLLOWING and SUBMIT A VOIDED CHECK

Account Type: ☐ **Checking** ☐ **Savings**

Bank Routing Number: ☐☐☐☐☐☐☐☐☐

Bank Account Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐