Age Range: 50-85

Oxford Quick Reference Tips

Ph. Interview # 833-705-4019, Press 2

Min Face Amount: $5,000 **Max Face Amount: $30,0000**

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
If "yes" to existing insurance question, a replacement form needs to be filled out **even if it no replacement is occurring**
When filling out replacement page, you only need to fill out replaced insurance company **IF you are replacing**

How to Quote with Cardinal Quoting App
Underwriting Type: Full
Product Type: Level

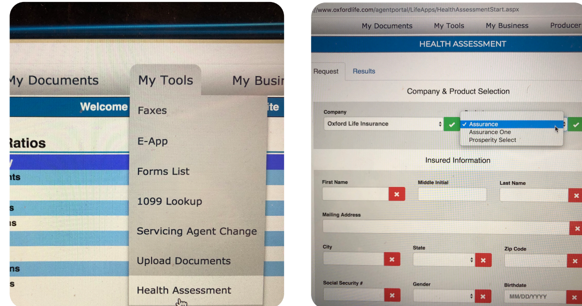
OXFORD LIFE INSURANCE CO...
Assurance
Premium: $43.10/mo*
Face Value: $10,000.00
Annual Fee: $37.50

Phone Interview / Online Health Assessment

Phone Interview
Before doing phone interview prep client for phone interview
Explain that you will give them all their basic health information, then they will want to speak to the client. They will record the conversation and have several authorizations for MIB/Prescirption Check, Ask if agent read the fraud statement, client must give "yes" answer to each.
Will ask them "Within the past 12 months, have you used any nicotine based products, any form of electronic cigarette (including nicotine-free electronic cigarettes), or marijuana?
Once client has been prepped dial 833.705.4019, press "2"

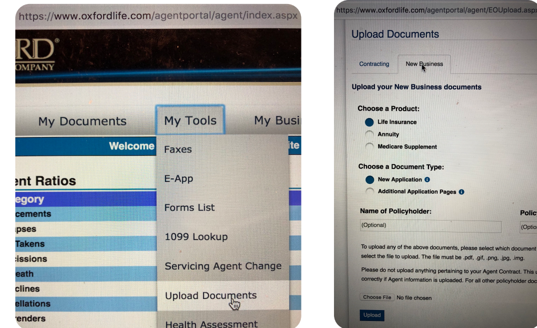
or

Online Health Assessment
Online Health Assessment is preferred because it is quicker, you don't have to prep client for interview, and can do it at anytime.
Login into oxford website
Click on "My Tools"———Click "Health Assessment"
Fill in blanks



How to Submit App
Delete instruction page before submitting

Upload through Oxford agent portal



-Or-

Cardinal Senior Benefits Submission Link:
https://www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

After submitting
Move file notability from "Applications" to "Client" folder.

Log client into **Senior Agent Tools** tracker

Current Height and Maximum Weight Chart

Height	Max Weight	Height	Max Weight
4' 2"	145	5' 6"	259
4' 3"	152	5' 7"	267
4' 4"	159	5' 8"	275
4' 5"	166	5' 9"	284
4' 6"	173	5' 10"	293
4' 7"	180	5' 11"	299
4' 8"	186	6' 0"	308
4' 9"	193	6' 1"	318
4' 10"	201	6' 2"	325
4' 11"	207	6' 3"	336
5' 0"	214	6' 4"	345
5' 1"	221	6' 5"	354
5' 2"	228	6' 6"	363
5' 3"	235	6' 7"	372
5' 4"	242	6' 8"	381
5' 5"	251	6' 9"	392

OXFORD®
LIFE INSURANCE COMPANY

ASSURANCE

Application for Individual Whole Life Insurance
Oxford Life Insurance Company
2721 North Central Avenue, Phoenix, Arizona 85004

Oxford Life InstaWrite 833-705-4019

SECTION A - PROPOSED INSURED INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)			
SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER ❑ MALE ❑FEMALE	PLACE OF BIRTH (CITY, STATE)
MAILING ADDRESS			EMAIL ADDRESS
CITY	STATE	ZIP	TELEPHONE NUMBER
STREET ADDRESS (**REQUIRED** IF MAILING ADDRESS IS PO BOX)			
CITY		STATE	ZIP

ARE YOU A U.S. CITIZEN? ❑ YES ❑ NO
IF NO, ARE YOU A LEGAL PERMANENT U.S. RESIDENT? ❑ YES ❑ NO **IF NO, COVERAGE IS NOT AVAILABLE.**
IF YES, PROVIDE THE ALIEN REGISTRATION/USCIS NUMBER AS SHOWN ON YOUR PERMANENT RESIDENT CARD: ______________________________

SECONDARY ADDRESSEE – We will send a copy of any notice of late payment or policy lapse to this person.
NAME & ADDRESS: ____

SECTION B – PROPOSED OWNER (Complete only if the proposed owner is not the proposed insured)

NAME (FIRST, MIDDLE INITIAL, LAST)			
SOCIAL SECURITY OR TAX ID NUMBER	DATE OF BIRTH	❑ MALE ❑ FEMALE	RELATIONSHIP TO PROPOSED INSURED
STREET ADDRESS			EMAIL ADDRESS
CITY	STATE	ZIP	TELEPHONE NUMBER

SECTION C - INSURANCE APPLIED FOR AND PREMIUM PAYMENT MODE

Amount of Insurance Applied for: $________________ Estimated Premium Amount (for selected payment mode): $____________
REQUESTED POLICY DATE: __________________________ (IF LEFT BLANK, THE POLICY DATE WILL BE THE DATE THE POLICY IS ISSUED)

Payment Mode (select one): ❑ Monthly Electronic Funds Transfer (EFT) ❑ Quarterly ❑ Semi-annually ❑ Annually

PAYOR NAME (IF PAYOR IS NOT PROPOSED OWNER)	RELATIONSHIP TO PROPOSED INSURED
BILLING ADDRESS (IF BLANK BILLING ADDRESS WILL BE SAME AS POLICY OWNER'S ADDRESS)	

Check here if Owner does NOT want the automatic premium loan provision included in the policy: ❑

MAIL POLICY TO: ❑ Owner ❑ Producer

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SECTION D - BENEFICIARIES

Percentages for each beneficiary class (primary and contingent) must total 100%. Multiple beneficiaries of the same class will share the death benefit equally unless percentages are listed.

Primary Beneficiaries

Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent

Contingent Beneficiaries

Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent
Name		Address	
Date of Birth	Social Security/Tax ID Number	Relationship	Percent

SECTION E - EXISTING COVERAGE AND REPLACEMENT

Does the Proposed Insured or the Proposed Owner have any existing life insurance or annuity policies?

❑ Yes ❑ No

Will the purchase of the life insurance policy applied for in this application result in the replacement, termination or change in value of any existing life insurance or annuity policy?

❑ Yes ❑ No

SECTION F – STRANGER OWNED LIFE INSURANCE

NOTICE: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

HAS THE OWNER, PROPOSED INSURED OR ANY BENEFICIARY ENTERED INTO OR MADE PLANS TO ENTER INTO ANY AGREEMENT TO SELL OR ASSIGN THE OWNERSHIP OF, OR A BENEFICIAL INTEREST IN, THE APPLIED FOR POLICY?

❑ YES ❑ NO **IF YES, PLEASE PROVIDE DETAILS:** ______________________________

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SECTION G – MEDICAL QUESTIONS

Part 1 - If any question in this Part 1 of Section G is answered yes, or if the proposed insured's height and weight are not within the allowable range, this application will be declined.

Question	Answer
1. What is the proposed insured's height and weight?	H ____ W ____
2. Have you had, or been advised to have by a member of the medical profession, an organ transplant, or have you been diagnosed by a member of the medical profession as having a terminal illness (an illness that would reasonably be expected to cause death within 12 months), or have you been diagnosed, treated (including dialysis) or taken medication for chronic kidney disease or kidney (renal) insufficiency or kidney or liver failure, or do you have paralysis of two or more extremities?	❑ YES ❑ NO
3. Have you been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or any immune deficiency related order, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑ YES ❑ NO
4. Are you currently: hospitalized, confined to a bed or nursing facility, using oxygen equipment to assist in breathing, or receiving Hospice Care?	❑ YES ❑ NO
5. Have you been diagnosed by a member of the medical profession with diabetes prior to age 30 or have you ever been treated by a member of the medical profession for: insulin shock, diabetic coma, retinopathy, or diabetic neuropathy?	❑ YES ❑ NO
6. Have you ever been diagnosed by a member of the medical profession, treated or taken medication for: Congestive Heart Failure (CHF) or heart failure, cardiomyopathy, Alzheimer's disease, dementia, schizophrenia, bipolar disorder, organic brain syndrome (acute or chronic mental dysfunction or mental incapacity), Lou Gehrig's disease (ALS), or Huntington's disease?	❑ YES ❑ NO
7. Within the past 24 months, have you been confined more than twice to a hospital, nursing facility, convalescent care facility, assisted living facility, mental facility or Hospice Care?	❑ YES ❑ NO
8. Within the past 24 months have you been diagnosed or treated by a member of the medical profession for: Internal cancer or melanoma, leukemia, lymphoma, stroke, transient ischemic attack (TIA), or have you had an amputation caused by any disease?	❑ YES ❑ NO
9. Have you been diagnosed or treated by a member of the medical profession for more than one occurrence or any metastasis of any cancer in your lifetime (excluding basal or squamous cell skin cancer), or are you currently being treated by a member of the medical profession for cancer or recurrence of cancer?	❑ YES ❑ NO
10. Within the past 24 months have you: a. been medically diagnosed or treated by a member of the medical profession or taken medication for angina, chronic hepatitis, cystic fibrosis, Pulmonary Fibrosis, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, respiratory failure or required oxygen equipment to assist in breathing?	❑ YES ❑ NO
b. been medically diagnosed as having or been treated by a member of the medical profession or hospitalized for heart attack, heart disease, heart or circulatory surgery (including pacemaker, by-pass, heart valve replacement, angioplasty or stent implant), uncontrolled high blood pressure or any procedure to improve circulation to the heart or brain?	❑ YES ❑ NO
c. been medically diagnosed or treated by a member of the medical profession for: Hodgkin's disease, cirrhosis, liver disease, systemic lupus (SLE), any neuromuscular disease, cerebral palsy, multiple sclerosis or Parkinson's disease?	❑ YES ❑ NO
11. Within the past 10 years, have you been convicted of a felony or are you currently on parole or on probation?	❑ YES ❑ NO
12. Within the last 5 years have you been treated for, been advised by a medical professional to have treatment for, or excessively used, alcohol or any drugs of abuse, or have you been convicted of operating a vehicle while impaired or under the influence of alcohol or any drugs, or had your driver's license suspended or revoked, or attempted suicide?	❑ YES ❑ NO
13. Have you been declined or postponed for life or health insurance in the past two years?	❑ YES ❑ NO
14. Do you currently require human assistance or supervision with any specified activities such as: eating, dressing, toileting, bathing, transferring from bed to chair, walking, or maintaining continence?	❑ YES ❑ NO

Part 2 - If any question in this Part 2 of Section G is answered yes, it may not necessarily cause this application to be declined.	
15. Are you taking or have you been prescribed medication by a member of the medical profession for any impairment in Section G?	❑ YES ❑ NO
16. Within the past 12 months, have you used any nicotine based products, any form of electronic cigarette (including nicotine-free electronic cigarettes), or marijuana?	❑ YES ❑ NO
17. Have you applied for life insurance with any other insurance companies in the last two years?	❑ YES ❑ NO
18. Proposed insured's driver's license number ______________________ State _____ ❑ None	

REPRESENTATIONS, AUTHORIZATIONS AND SIGNATURE

MEDICAL AND CONSUMER REPORTS AUTHORIZATION (this authorization complies with the HIPAA Privacy Rule): For underwriting and claims purposes, I authorize any physician, medical practitioner, hospital, medical care facility, pharmacy, pharmacy benefit manager, the Veteran's Administration or other health care provider, and any insurance company, insurance support organization (such as MIB, Inc. ("MIB")), insurance laboratories, my employer, consumer reporting agency or state department of motor vehicles, to disclose information about me, including but not limited to, my entire medical record, or any other protected health or consumer information, to Oxford Life Insurance Company ("Oxford Life"), its reinsurers and those who perform services for Oxford Life related to an insurance application or a claim. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases and mental illness, and the use of alcohol and drugs. I agree that a copy of this authorization or my recorded voice or electronic authorization is as valid as the original and I can obtain a copy on request. This authorization is valid for 36 months (or a shorter time period if required by applicable state law) from the date of this application (180 days for HIV-related information), regardless of my condition and whether living or deceased. I can revoke this authorization at any time by written notice to Oxford Life (Attention: Policyholder Services Department, 2721 N. Central Ave., Phoenix, AZ 85004). Revocation will not be effective to the extent that this authorization has been relied upon or to the extent that Oxford Life has a legal right to contest a claim under an insurance policy or to contest the policy itself. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations (such as the HIPAA Privacy Rule). However, Oxford Life will protect the privacy of health information in accordance with applicable state and federal privacy laws and its own privacy policies. I authorize Oxford Life, or its reinsurers, to make a brief report of my protected health information to MIB. I acknowledge receipt of the MIB Pre-Notice, the Fair Credit Reporting Act Notice and the Privacy Notice. I understand that my health care providers may not condition providing treatment or payment for health care services on my signing of this authorization. I further understand that if I refuse to sign this authorization Oxford Life will not be able to process my application.

____ Date: ________________________

Signature of Primary Proposed Insured/Personal Representative

If signed by an individual's Personal Representative, please describe authority to sign on behalf of the individual:

❑ Power of Attorney ❑ Other (please describe): ____

REPRESENTATIONS AND ACKNOWLEDGEMENTS:

I have read and understand this 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 fully complete this application. Under penalties of perjury, I certify that I am a U.S. citizen (including a U.S. resident alien) and that my correct taxpayer identification number is shown on this form. All statements and answers in this application are true and complete to the best of my knowledge and belief, are the basis for any policy issued, and will be made a part of the policy. No information about me will be considered to have been given to Oxford Life by me unless it is stated in this application or during the application process.

The producer does not have authority to: accept risk, pass on insurability, waive, make void, change, or modify any provisions, questions or answers given in this application, approve this application, change the policy, or advise me that any inaccurate application response is acceptable.

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NO IMMEDIATE LIFE INSURANCE COVERAGE.

Oxford Life will have no liability under this application unless, and until: a) the application has been received and approved by Oxford Life at its Home Office; b) the policy has been issued and delivered to the owner during the lifetime of the Proposed Insured; c) the first premium has been paid to and accepted by Oxford Life and honored by the issuing financial institution on the policy applied for; and d) at the time of delivery and payment, the facts concerning the insurability of the Insured remain as stated during the application process.

WARNING: 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.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. OXFORD LIFE WILL RELY ON THIS APPLICATION TO DETERMINE INSURABILITY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS BY RESCINDING YOUR POLICY. RESCINDING YOUR POLICY WILL HAVE AN ADVERSE IMPACT ON YOUR INTENDED BENEFICIARY.

Signed at (City, State): ________________________________ **Date:** ______________________

____ ____

Signature of Proposed Insured Signature of Proposed Owner

PRODUCER'S REPORT AND SIGNATURE

Do you have reason to believe that the Proposed Insured or the Proposed Owner has any existing life insurance or annuity policies? ***If yes, a replacement form is always required in states that have adopted the NAIC model replacement regulation, even if the policy applied for in this application will not actually replace any existing coverage.***

❑ Yes ❑ No

Do you have reason to believe that the insurance applied for in this application will result in the replacement, termination or change in value of any existing life insurance or annuity policy? ***If yes, all requested information about any replaced policy must be provided on the replacement form.***

❑ Yes ❑ No

I certify the following to Oxford Life: I personally solicited this application and all information recorded on this application is true to the best of my knowledge. The Proposed Insured and Owner seemed to me to be lucid and fully understand all of the questions on this application. If this transaction involves a replacement, I gathered all relevant information regarding the replaced product and determined that the replacement is suitable and in compliance with the Company's position on replacements. To my knowledge, the policy applied for will not be sold or assigned for any type of senior settlement, life settlement or any other secondary market.

Producer's Signature______________________________________ Date ________________

Producer's Printed Name ____________________________________ Producer's Number ________________

OXFORD®
LIFE INSURANCE COMPANY

ASSURANCE
FINAL EXPENSE LIFE INSURANCE

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

POLICY NUMBER:		BANK ACCOUNT TYPE: ❑ CHECKING ❑ SAVINGS
BANK ACCOUNT OWNER NAME ❑ SAME AS INSURED ❑ SAME AS POLICY OWNER or PRINT NAME:		
BANK ACCOUNT OWNER ADDRESS		RELATIONSHIP TO INSURED
BANK NAME	ROUTING NUMBER	BANK ACCOUNT NUMBER

USE THIS SECTION ONLY IF YOU WANT TO REQUEST A PAYMENT DATE AND POLICY DATE THAT COINCIDES WITH YOUR SOCIAL SECURITY PAYMENT DATE.

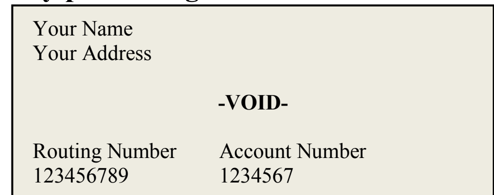
Please make my policy date and draft date the:

❑ Second Wednesday ❑ Third Wednesday ❑ Fourth Wednesday

Please also write "See EFT Form" next to Requested Policy Date in Section C of the Application.

For checking accounts, attach a voided check over this section. For savings accounts, attach a bank account statement. DO NOT ATTACH A DEPOSIT SLIP. A deposit slip may delay processing.

Refer to this diagram for instructions on where to locate your bank routing and account numbers.



Oxford Life will draft the first premium at the time the policy is effective or issued, whichever is later. Subsequent drafts will occur on the same day of the month as the policy's effective date (or the Social Security payment date if that option is selected).

I have read, understand and agree to the following:

I authorize Oxford Life Insurance Company to electronically debit all premiums (at the rate for the payment frequency selected in my application) from the bank account identified above. If the premium for the face amount applied for differs from the estimated premium quoted on an application submitted with this form, I authorize Oxford Life to debit the actual premium amount due from my bank account. This authorization may be terminated by me or by Oxford Life. I may revoke this authorization by written notice to Oxford Life or by calling (866) 641-9999. If this authorization is revoked, Oxford Life will initiate quarterly paper billings. Oxford Life will NOT consider my premium paid if my bank does not honor an EFT request. If a bank return is received due to insufficient funds, Oxford Life will attempt a second draft from your bank account immediately upon notice of the first return. Any bank fees incurred due to bank returns will not be reimbursed by Oxford Life.

IF THE POLICY OWNER IS NOT THE OWNER OF THE BANK ACCOUNT IDENTIFIED ABOVE, THEN THE BANK ACCOUNT OWNER MUST ALSO SIGN THIS FORM.

Signature – Policy Owner Date

Signature – Bank Account Owner Date

Oxford Life Mailing Address and Contact Information						
Regular mail or overnight	**Marketing**		**New Business**		**Existing Policies**	
2721 North Central Avenue, Phoenix, AZ 85004	Phone	800-308-2318	Phone	866-641-9999	Phone	866-641-9999
	Fax	866-380-9691	Fax	877-584-2777	Fax	877-584-2777
	E-Mail	marketing@oxfordlife.com	E-Mail	fastapps@oxfordlife.com	E-Mail	oxfordphs@oxfordlife.com

OXFORD®
LIFE INSURANCE COMPANY

2721 North Central Avenue • Phoenix, Arizona 85004 • 602-263-6666 or 800-308-2318

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, with a copy left with the applicant and a copy returned to the office.

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 or contract 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 or contract 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
3. If you answered "YES" to either one 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______________________________.
Reason for Replacement

ACKNOWLEDGMENT

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

______________________________ ______________________
(Applicant's Signature and Printed Name) (Date)

I do not want this notice read aloud to me. [ ] (Applicant must initial only if they do not want the notice read aloud.)

PRODUCER STATEMENT

I certify that the responses herein are, to the best of my knowledge, accurate. I further certify that I only used sales materials previously approved by Oxford Life Insurance Company in conjunction with this sale and that copies of all sales materials used in this sale have been left with the applicant. Any electronically presented sales materials will be provided in printed form to the applicant not later than at the time of policy delivery:

______________________________ ______________________
(Producer's Signature and Printed Name) (Date)