

Application for **Term Life**



INTERNATIONAL

A division of Morgan White Group

75 Valencia Avenue, Suite 801
Coral Gables, FL 33134

Primary Insured

Individual

Group

Last name		First	Initial	Sex	Smoker? Yes No
Country of birth	DOB (Day/Month/Year)		Age	Height (ft/inch)	Weight (lbs)
Home address		City	Country & Zip		
Mailing address		City	Country & Zip		
Occupation and duties			Annual Income	\$	
Country of citizenship	Email address (required, cannot be agent's email)			Home phone/Cell	
Employer Information					
Employer name		Type of business/industry	Employer phone		
Employer address		City	Country & Zip		

Owner (If not the primary insured)

Full name	Relationship to insured
Address	City Country & Zip
Occupation and duties	Annual Income \$

Term Life Product	Coverage Amount Applying for	Cash Value/Return of Premium?
10 Year Term to Age 85	\$ _____	Yes No
25 Year Term		
30 Year Term		
Term to Age 80		
	Critical Illness Rider (optional)	Waiver of Premium Rider?
	\$10,000 \$20,000 \$30,000 N/A	Yes No

Frequency of Payment	Mode of Payment	Please provide Customer ID below if you are an existing client.
Annual Semiannual Monthly	Check (make payable to: MWAll Premium Trust) Credit Card Wire Transfer (\$15.00 fee)	
Total Premium Due (This amount must match the total premium shown on the Proposal PDF)		\$
Once your application has been submitted, you will receive a Customer ID and Certificate Number . Please use those numbers to submit your payment information in the Online Payment Portal .		

Telephone Interview

As a requirement, if you are requesting a sum insured between \$500,000 and \$1,000,000, you will be contacted by a representative to verify your health history.

The best time to call would be: _____ a.m. _____ p.m. Phone number: _____

Part I Questions *Provide Complete Answers for the Applicant*

For "Yes" answers, give details in the "Part II Details" section or complete the appropriate questionnaire required by the company.

Part A: Non Medical Questions		Yes	No
1. Have been declined, postponed, or charged an extra premium for life insurance?			
2. Do you intend to travel to any foreign country within the next two years? What countries?			
3. In the past 10 years, have you:			
a	Been a pilot or crew member of an airplane, or been on a balloon, hang glider or like device, or jumped therefrom?		
b	Been a vehicle racer, diver, parachutist, mountain climber, bungee jumper, or participant in a hazardous sport or hobby?		
c	Been convicted or driving under the influence of alcohol or drugs, of a criminal offense, or is now incarcerated, on parole or probation, or has been subject to kidnapping or ransom or has had death threats?		
d	Been convicted of four or more driving violations or had driver's license suspended or revoked?		
e	Drink alcohol in excess, been treated or counseled by a healthcare provider for alcohol use, attended or are attending a support group for help to stop alcohol use.		
f	Used cocaine, marijuana, heroin, amphetamines, narcotics, stimulants, or other illegal drugs or controlled substances?		

Part B: Medical Questions		Yes	No
1. Have you ever had, or received medical advice or treatment for:			
a	High blood pressure, stroke, anemia, chest pain, heart attack, disease or disorder of the blood, heart arteries, or veins?		
b	Ulcers, or diseases or disorders of the stomach, intestines, liver, gall bladder, or rectum?		
c	Prediabetes, diabetes, cancer, tumors, cystic fibrosis, autoimmune diseases, leukemia, disorder of the pancreas, thyroid, adrenal or lymphatic system, or other glands.		
d	Epilepsy, convulsions, nervous or mental disorder, paralysis, or disorder of the brain or nervous system?		
e	Disease of the kidney, bladder, genital organs, or had sugar, albumin, or blood in the urine?		
f	Asthma, emphysema, tuberculosis, chronic bronchitis, or disease of the lung, chest, or throat?		
2. In the last 6 months, have you had a sudden involuntary loss of weight of more than 10 pounds?			
3. Other than as answered above, within the past 5 years, have you:			
a	Been admitted to a hospital, treatment center, or other facility?		
b	Been treated for acquired immunodeficiency syndrome (AIDS) or tested positive for the HIV virus?		
c	Requested or received payments or reimbursements for a mental or physical disability?		
d	Been advised to have surgery, hospitalization, treatment, or diagnostic test not yet completed?		
4. Are you currently taking, or have taken, medication for any disease or condition not indicated above?			

Family or Personal Physician's Information	
Name	Telephone number
Address	

Part C: Tobacco and Tobacco Use Questions		Yes	No
1. Do you Smoke?			
2. Cigarettes?			
a	If "yes," how many per day?		
3. Cigars, Pipe, E-Cigarettes or any other form of tobacco?			
a	If "yes," specify the type and frequency?		

Primary applicant's initials: _____

If you answered "Yes" to any of the questions in the "Part I Questions" section, please complete this form or indicate the required information below:

No.	Applicant's name	Diagnosis, treatments, results	Date Day/Month/Year	Physician/Hospital details

Part A: Existing and Pending Insurance Questions				Yes	No
1. Do you currently have any life insurance policy in force, or do you have an application(s) pending in any other company?					
2. Do you intend to replace an existing policy with this one?					
If answered "yes," to Question 1, please provide the following information below:					
Company Name	Policy Number	Face Amount US\$	ADB Face Amount US\$	Year Issued	

Beneficiary Designation <i>Total designated beneficiary share percentage must equal 100%. Please use last page of the application to list more as needed.</i>			
All benefits are assigned to the designated beneficiary.		In the event of death of beneficiary.	
Beneficiary	Percentage: %	Contingent Beneficiary	Percentage: %
Name:		Name:	
Date of birth (DD/MM/YY):		Date of birth (DD/MM/YY):	
Address:		Address:	
Phone:		Phone:	
Relationship:		Relationship:	

Primary applicant's initials: _____

Applicant's Statement

I hereby certify all responses and declarations contained in this application are true, complete and correct and I understand and agree any inaccuracy or omission in responses will constitute grounds for the Company to deny a claim, invalidate or cancel any of the insurance coverage applied for. In the event the Company cancels or otherwise invalidates the insurance coverage applied for as a result of the failure to fully disclose past medical history or pre-existing conditions, the Company reserves the right to recover from the applicant all costs and fees incurred in reasonably investigating those matters not fully disclosed.

I understand the broker, agent or agency receiving this application does not have the authority to modify or waive any portion of this application or any coverage, conditions or restrictions contained in the insurance policy applied for and all information requested in the application must be set forth in writing on this application. I further understand this application will become part of the insurance policy to be issued and the Company will be utilizing the information contained in this application to determine whether or not to issue the insurance policy applied for.

I understand the broker, agent or agency taking this application from me is an independent representative and is acting on my behalf and not the administrator nor the insurance company offering this insurance. Neither the administrator nor the Company offering this insurance can be held liable for any circumstance if the broker, agent or agency, who is taking this application, fails now or in the future to transmit or communicate any documentation or funds from the administrator to me and/or any documentation or funds from me to the administrator. All premium payments must be made payable to the Company. The Company is not responsible for payments made in cash, or payable to a third party.

It is understood the insurance applied for shall not become effective until this application is approved and accepted by the Company, full payment of the first premium is made, and the policy issued, subject to all conditions and restrictions contained therein. I understand this policy is not available to permanent residents of the United States or others who reside in the United States.

Signature of proposed applicant _____ Date _____ / _____ / _____
Day Month Year

Medical Authorization

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, the Medical Information Bureau, Inc. (MIB, Inc.) or other organization, consumer reporting agency, insurance or reinsuring company, institution or person having any record or knowledge of me or my health, including any member of my family, to give to the insurer offering the insurance, any reinsurer or its legal representative any and all such information. The nature of the information authorized to be disclosed includes information about all medical evaluation, care, treatment, diagnosis or consultation provided to the undersigned insured, or my dependents. I understand the information obtained by use of this authorization will be used by the insurer offering the insurance, and its reinsurers to determine eligibility and payment of claim benefits under this policy. I direct that a copy of this authorization shall be given the same force and effect as the original. This authorization shall remain valid as long as this policy is in force.

Signature of proposed primary insured _____

Signature of owner (if different than Proposed Primary) _____
If business insurance, show the title of officer and name of firm

I personally solicited and completed this application. All medical and non-medical questions were asked of the proposed insured and his or her answers were recorded as given or the answers were made by the proposed insured in his or her own handwriting.

Agent signature / Witness: _____ Agent code: _____

Agent email: _____ Date _____ / _____ / _____
Day Month Year

Email completed, signed enrollment form and quote to:
newbuss@morganwhiteintl.com

Additional Beneficiaries (optional)

Primary Beneficiary 2				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
Primary Beneficiary 3				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
Primary Beneficiary 4				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
Contingent Beneficiary 2				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
Contingent Beneficiary 3				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
Trustee (required if listing a minor child as Beneficiary)				
Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
Mailing address	City	Country		
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Name	Relationship	Age	DOB (Day/Month/Year)	Percentage
Home address	City	Country		Phone
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