Documents Package Prepared for: **The Brokers Network**

Prepared Date: **10/10/2018 5:35 PM EST**

Document Name	Description	Expiration Date
RHA - Life Forms	The Brokers Network life new business forms	12/31/2199
LAA1297WP	Request for Life Insurance Interview	12/31/2199
LU1321WP	Request and Authorization for Electronic Poli...	12/31/2199

The Brokers Network Life Insurance Application Transmittal

☎ 407-898-5521 | 800-749-9900 🖷 407-896-0924 💻 www.thebrokersnetwork.com

Proposed Insured: ______________________________

Agent: ______________________________________

Submit application package to:
The Brokers Network
431 East Horatio Ave, Suite 210
Maitland, Florida 32751

Did you order the Medical Requirements? ☐ No ☐ Yes Service: __________________________

Quoted Modal Premium: _________________________ Mode: ____

Rate Class: ☐ Preferred Best ☐ Preferred ☐ Standard Plus ☐ Standard ☐ Rated

Nicotine/Tobacco Usage: ☐ None ☐ Cigarettes ☐ Cigars/Pipe/Chew
☐ Marijuana ☐ e-Cigarettes ☐ Patch/Gum

Preliminary Medical Information:

Height: ________________________________ Weight: _____________________________________

Is the Proposed Insured taking medication to control: ☐ Hypertension ☐ Total Cholesterol

Has a parent or sibling ever been diagnosed or died from any of the following:

Condition	Family Member	Age at Diagnosis	Age at Death
Cancer			
Cardiovascular			
Coronary Artery Disease			
Cerebrovascular Disease			
Diabetes			

Details/Purpose of Insurance:

Personal: ☐ Family Needs ☐ Estate Planning ☐ Other _________________________

Business: ☐ Buy/Sell ☐ Keyperson ☐ Debt Recovery

1035 Exchange: ☐ No ☐ Yes Amount $ _________________________

LTC Benefit Rider: ☐ No ☐ Yes Amount $ _________________________

Comments: ____

____

____

A signed illustration with ALL numbered pages is required at submission for all cash value products.

Rex Huffman & Associates, Inc.

431 East Horatio Ave, Suite 210 Phone 407.898.5521
Maitland, Florida 32751 Fax 407.896.0924

HIPAA Authorization to Release Information

For the purpose of obtaining the insurance coverage that I have requested, I hereby authorize Rex Huffman & Associates, Inc., dba The Brokers Network (the “Representative”) and its affiliated agencies, to disclose my personal financial and health information to the insurance companies listed at the bottom of this page and to insurance agents and brokers acting on my behalf with respect to obtaining such insurance coverage.

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, Pharmacy Benefit Manager or other health care provider that has provided treatment or services to me or on my behalf within the past 10 years (“my Providers”) to disclose my entire medical record and any other information that may be considered protected health information under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) concerning me to the Representative and its staff, affiliated companies and/or entities, insurance companies and their re-insurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPAA protected health information do not apply for purposes of this authorization and I instruct my Providers to release and disclose my entire medical record without restriction to the Representative. I understand that any information that is disclosed pursuant to this authorization may be subject to re-disclosure and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of the insurance companies listed at the bottom of this page and their re-insurers as well as the Representative and its staff, employees and affiliated companies.

I also request, authorize, and direct the Representative, and its affiliated agencies, to disclose my personal contact and demographic information to Wamberg Genomic Advisors, Inc. for purposes of my obtaining information on and/or applying tor the Cancer Guardian Program or other programs offered by Wamberg Genomic Advisors, Inc.

This authorization shall be valid for twelve (12) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

I understand that I may write to the Representative to revoke this authorization and that the revocation will take effect when the Representative receives my written request. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I also understand that, to the extent that other law allows an insurance company listed below to contest a claim under an insurance policy or the insurance policy itself, my revocation of this authorization may not be effective.

I understand that if I refuse to sign this authorization, the Representative may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form, or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment or payment for services, or my eligibility for health care benefits; provided, however, that if a health care service (e.g, a physical exam) is requested solely for the purpose of creating protected health information to be disclosed to a third party, the health care provider may refuse to provide the service if I do not sign this authorization.

____
Proposed Insured’s Name

____
Agent’s Name

____
Proposed Insured’s Signature

____
Agent’s Signature

____
Date

____
City and State

Accordia Life & Annuity Company, Allianz Life Insurance Company of North America, American General Life Companies, American National Insurance Companies, AXA Equitable Life Insurance Company, Banner Life Insurance Company, Brighthouse Life Insurance Company, Brighthouse Life Insurance Company of NY, Cincinnati Life Insurance Company, First Symetra National Life Insurance Company of NY, General Re Life Corp, Genworth Financial Family of Companies, John Hancock, Life Insurance Company of the Southwest, Lincoln Life & Annuity Company of New York, Lincoln National Life Insurance Company, Minnesota Life, Mutual of Omaha, National Life Insurance Company, Nationwide Life Insurance Company, Nationwide Life and Annuity Insurance Company, New York Life Insurance and Annuity Corporation, New York Life Insurance Company, North American Company for Life & Health, Petersen International Underwriters, Principal Life Insurance Company, Principal National Life Insurance Company, Protective Life and Annuity Insurance Company, Protective Life Insurance Company, Pruco Life Insurance Company, Pruco Life Insurance Company of New Jersey, ReliaStar Life Insurance Company, ReliaStar Life Insurance Company of New York, Sagicor Life Insurance Company, Savings Bank Mutual Life Insurance Company of Massachusetts, Securian Life Insurance Company, Security Life of Denver Insurance Company, Symetra Life Insurance Company, Transamerica Insurance & Investment Group, United of Omaha Life Insurance Company, William Penn Life Insurance Company of New York, Zurich American Life Insurance Company, Zurich American Life Insurance Company of New York.

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Employer-Owned Life Insurance Notice and Consent

The following is a brief summary of the rules that apply to Employer-Owned Life Insurance polices, including buy-sell funding. These rules generally apply to contracts issued on August 18, 2006 or later. These rules also apply to policies issued before August 18th ("grandfathered policies") that undergo material increases in the death benefit or other material changes. Due to the complexity of the new rules, it is not entirely clear how they might apply in certain settings where an employer is not directly the owner or beneficiary of the policy. For example, when life insurance is acquired to fund a cross-purchase buy sell arrangement. In these situations it appears to be prudent to comply with the requirements of the law. While these instructions refer to the "employer" and "employee," the actual Form has been designed for use in both direct employer-owned and indirect employer-owned situations. This summary is not meant to be comprehensive or to cover every situation and should not be construed as tax or legal advice. You should consult with and rely on the advice of your own tax counsel.

As explained below, if "Notice and Consent" are received and certain Specified Exceptions are met, the death benefit of a life insurance policy owned by and payable to an employer on the life of an employee, will, generally, remain income tax-free. ***IF THESE RULES ARE NOT SATISFIED, THE DEATH BENEFIT WILL GENERALLY BE TAXABLE.***

I. "Notice and Consent"

The "Notice and Consent" requirements are satisfied if ***before*** the policy is issued or ***before*** there is a material increase or other material change to a grandfathered policy:

1. The employee is notified in writing that the employer intends to insure the employee's life,
2. The employee is notified in writing of the maximum face amount for which the employee could be insured at the time the policy was issued.
3. The employee provides written consent to being insured under the policy and that such coverage may continue after the insured terminates employment, and
4. The employee is informed in writing that the employer will be a beneficiary of any insurance proceeds payable on the death of the employee.

II. Specified Exceptions

In general, if the notice and consent requirements are satisfied, policy death proceeds may be received income tax free (subject to existing Transfer for Value and Alternative Minimum Tax rules) if any of the following exceptions are met:

1. **Recent Employees:** The insured was an employee at any time during the 12-month period before death. (In other words, if the employee is no longer employed by the employer at the time of death, the death proceeds will keep their income tax-free status if death occurs within the 12 months following the date of the employee's employment termination.)
2. **Directors and Highly Compensated Employees**: If at the time of the policy was issued, the insured was:
   a. a director
   b. a highly compensated employee under the rules for qualified retirement plans:
      (a) generally, owner of more than 5% of outstanding or voting stock of the employer (or more than 5% of capital or profits interest if employer is not a corporation) in the current or preceding year; or
      (b) an employee receiving compensation as follows: for policies issued in 2006, employee earned in excess of $100,000 in 2005; for policies issued in 2007, employee earned in excess of $100,000 in 2006, or
   c. a highly compensated individual under the rules for self-insured medical reimbursement plans, looking at the highest paid 35% of employees (i.e., generally one of the five highest paid officers, or among the highest paid 35% of all employees, or a more than 10% owner by value of employer stock.)
3. **Death Benefits Paid to Heirs**: To the extent that death proceeds paid in the taxable year are received:
      (a) by a family member of the insured,
      (b) by an individual who is the designated beneficiary of the insured (other than the employer),
      (c) by a trust established for the benefit of any such family member or designated beneficiary, or
      (d) by the estate of the insured.
4. **Buy/Sell Situations**: To the extent that death proceeds are used in the taxable year they are received to purchase an equity (or partnership capital or profits interest) in the employer from a family member, beneficiary, trust or estate.

The Brokers Network

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Phone 407.898.5521
Fax 407.896.0924

Employer-Owned Life Insurance Notice and Consent

Employee/Proposed Insured Information

Name: ____

Social Security #: ______________________ Date of Birth: ___________________________

Employer/Policyowner Information

Company Name: ____

Tax ID #: ______________________________ Address: ______________________________

Notice by Employer/Policyowner

- Employer intends to apply for insurance on the life of the Employee (Proposed Insured).
- The maximum face amount the Employee/Proposed Insured could be insured for at the time the contract is issued is $__________________________.
- The Employer will be the Policyowner of any policy issued and a beneficiary of any proceeds payable upon the Employee/Proposed Insured's death.

Consent of Employee/Proposed Insured

- I consent to being an insured under the insurance policy for which my Employer intends to apply.
- I consent to my Employer continuing coverage, after my employment ends, under any policy issued.
- I understand that my Employer will own the policy. Unless provided in a separate agreement, my Employer will receive all of the death proceeds and my personal representative, next of kin, and heirs at law will have no beneficial interest in the policy or its death proceeds.

Acknowledgement

This form is provided as a convenience to the employer and to obtain information that may be needed for information reporting services. By providing this form, Rex Huffman & Associates, Inc. makes no representation that completing it will constitute compliance with any law or regulation, tax or otherwise. Federal tax law specifies that the death benefits of certain employer-owned life insurance contracts will not be completely excluded from federal gross income of the employer unless notice-and-consent requirements specified in the law are fulfilled. Rex Huffman & Associates, Inc. and its affiliated agencies do not provide tax or legal advice. We did not create this form for use by any taxpayer to avoid any Internal Revenue Service penalty. You should ask your independent tax and legal advisors for advice based on your particular situation. A photocopy of this form shall be as valid as the original.

Employee Signature: _______________________________________ Date: ____________________

Employer Signature: _______________________________________ Title: ____________________

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The Contracting Warehouse

We no longer offer paper contracting kits for the majority of our carriers. Instead, we now offer the **Contracting Warehouse**, your virtual contracting assistant. All your pertinent information (your profile) will be safely stored in the Contracting Warehouse to make your new appointments with our carriers an almost effortless process.

All your information is stored on multi-level secured servers and will only be accessible by you, those you give your access information to and our office staff.

First time users will need to create their profile in the **Contracting Warehouse**. You will be asked questions regarding your personal information, addresses, business information, employment history, carrier affiliations, license information, errors and omissions coverage, legal information, direct deposit information and some additional specific information required by our carriers. The entire process should take about 20-30 minutes. Once your profile is completed, we will pull any required contracting as you submit business.

Participating carriers:

- Accordia Life & Annuity
- Allianz Life
- Allianz Life of NY
- American Equity
- American General
- American National
- American National of NY
- Athene Annuity & Life
- AXA Equitable Life
- Banner Life
- Brighthouse Life
- Brighthouse Life of NY
- Cincinnati Life
- Fidelity & Guaranty
- Fidelity & Guaranty of NY
- First Symetra National Life
- Forethought Life
- Genworth Financial
- Great American
- Guardian Life of America
- Guggenheim Life & Annuity
- Illinois Mutual
- Integrity Life
- John Hancock Life USA
- John Hancock Life of NY
- Legacy Marketing Group
- Lincoln Financial
- Minnesota Life
- MONY Life of America
- Mutual of Omaha
- National Integrity
- Nationwide
- North American Company
- OneAmerica/State Life
- Peterson Int'l Underwriters
- Principal Financial
- Protective Life
- Protective Life and Annuity
- Prudential Financial
- Reliance Standard
- ReliaStar Life
- ReliaStar Life of NY
- Sagicor Life
- Savings Bank Life of Mass
- Securian Life
- Security Life of Denver
- Standard Insurance
- Symetra Life
- Transamerica Financial NY
- Transamerica Life
- United Home Life
- United of Omaha
- United States Life of NY
- William Penn of NY
- Zurich American Life
- Zurich American Life of NY

To get started, log in to our website at **www.thebrokersnetwork.com** and then click on **Contracting Warehouse** found in the Quick Links section on the right side of the Welcome page. If you are not sure what your login codes are or are not yet a member of the Brokers Network, please contact Beth Stemerman at ext. 130 for assistance.

Please direct any questions to Beth Stemerman
407-898-5521 or 800-749-9900, ext. 130

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
3275 Bennett Creek Avenue
Frederick, Maryland 21704
800-526-5568

Date of Request:__________________

Request for Life Insurance Interview

*** ALL FIELDS MANDATORY**

PROPOSED INSURED

*** This program is not available in New York for replacement of existing insurance.**

______________________________ (First Name, Middle, Last Name)   XXX-XX-__________ (Last 4 digits S.S.#)   Date of Birth ________/______/________ (Month) (Day) (Year)

RISK EVALUATION

If answer to question is not known, please leave blank.
Criteria Questions

Check One Classification For Each Question

	Question	If No...	If Yes...	Classification
1	1a. Do you have a history of alcohol or substance (drug) abuse? 1b. Has there been any abuse in the past 10 years?	Check P+ and go to question 2. Check P and go to question 2.	Go to question 1b. Check S and go to question 2.	P+ / P / S
2	Have you had any DUIs in the past 2a. 5 years? 2b. 3 years?	Check P+ and go to question 3. Check S+ and go to question 3.	Go to question 2b. Check S and go to question 3.	P+ / S+ / S
3	Have you had more than two motor vehicle moving violations in the past three years?	Check P+ and go to question 4.	Check S+ and go to question 4.	P+ / S+
4	4a. Has either parent or a sibling had a history of cardiovascular disease before age 60? 4b. Has either parent died as a result of cardiovascular disease before age 60? 4c. Have both parents died as a result of cardiovascular disease before age 60?	Check P+ and go to question 5. Check P and go to question 5. Check S+ and go to question 5.	Go to question 4b. Go to question 4c. Check S and go to question 5.	P+ / P / S+ / S
5	What is your height? ________ weight? ________ Based on height and weight, select the underwriting classification according to the build chart below. If weight meets or exceeds limit for standard (S) class, check S.			P+ / P / S+ / S
6	Have you used any nicotine-based products in the past 6a. 36 months? 6b. 24 months? 6c. 12 months?	Check P+ and go to question 7. Check P and go to question 7. Check S+ and go to question 7.	Go to question 6b. Go to question 6c. Check PT if answers from 1 to 5 are all P/P+, otherwise, check ST.	P+ / P / S+ / PT / ST
7	**What is the lowest (on a scale where P+ is highest) underwriting class checked in any of the answers to questions 1-6?**		**Check one box.**	**P+ / P / S+ / S / PT / ST**

This questionnaire is designed to provide a tentative premium classification based on a portion of the criteria used to determine a final premium classification. Final approval, classification, and actual rates will be subject to and based upon the entire underwriting process, your medical history, information developed during your interview with the William Penn Call Center representative and/or any specific underwriting requirements and criteria. Please refer to the policy form for full disclosure of benefits and limitations. Forms and policy provisions may vary by state. Not available in all states.

Build Chart

Height	Minimum Weight	P+		P	S+	S	S	Height	Minimum Weight	P+		P	S+	S	S
		Male	Female	M/F	M/F	M/F	M/F			Male	Female	M/F	M/F	M/F	M/F
4'10"	89	135	126	148	156	181	196	5'11"	133	201	175	221	231	272	293
4'11"	92	140	131	154	162	188	203	6'0"	136	207	180	228	240	280	302
5'0"	95	144	135	158	166	194	209	6'1"	140	213	184	234	245	288	310
5'1"	98	148	138	163	172	201	217	6'2"	144	219	188	241	253	295	319
5'2"	101	153	140	168	175	207	224	6'3"	148	225	193	247	259	304	328
5'3"	104	158	143	174	182	214	231	6'4"	152	230	197	253	265	312	336
5'4"	108	163	145	179	188	221	238	6'5"	156	237	201	260	272	320	345
5'5"	111	168	148	185	194	228	246	6'6"	160	243	205	267	280	328	354
5'6"	115	174	150	191	200	235	254	6'7"	164	249	209	274	287	337	363
5'7"	118	179	155	197	206	242	261	6'8"	168	256	214	281	294	345	373
5'8"	122	185	160	203	212	249	269	6'9"	173	262	218	288	302	354	382
5'9"	125	190	165	209	219	257	277	6'10"	177	268	222	295	309	363	392
5'10"	129	196	170	215	226	264	285	6'11"	181	276	226	303	317	372	401

Legend	
P+	Preferred Plus
P	Preferred
S+	Standard Plus
S	Standard
PT	Preferred Tobacco
ST	Standard Tobacco

PROPOSED INSURED INFORMATION

Proposed Insured ______________________

Quoted Premium $ ______________ Face Amount $ ______________

Product (Please check only one.)

- OPTerm ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30
- Term Rider ☐ 10 ☐ 15 ☐ 20
- Child Rider ☐ 5K ☐ 10K
- Other ☐ ______________

Payment method ☐ Direct Bill ☐ Electronic Funds Transfer (EFT)

Frequency of premium payment ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT Only)

Gender ☐ Male ☐ Female

Is this prospective policy to replace existing insurance? ☐ Yes ☐ No

If yes to replacing, the existing policy or contract is being replaced because: ______________________

What is the purpose of this insurance? ☐ Buy/Sell ☐ Keyman ☐ Family Protection ☐ Income Replacement ☐ Other ______________

Policy Owner (if other than Proposed Insured) Name ______________________

City, State ______________________ Zip ______________

Date to Save Age ☐ Yes ☐ No

Waiver of Premium ☐ Yes ☐ No

TIAA - If your client is eligible, would you like us to offer temporary insurance coverage? ☐ Yes ☐ No

Exam Provider ☐ APPS-Portamedic ☐ EMSI ☐ ExamOne-Superior Mobile Medics

(Available Interview Hours: Monday - Friday, 9:00 a.m. to 10:30 p.m. ET)

Please contact me: Date ____________ (MM/DD/YY) Local time: ____________ ☐ AM ☐ PM

The William Penn Call Center will contact you within two hours of the designated time.

Primary Telephone No. ______________________ ☐ Home ☐ Work ☐ Cell

Secondary Telephone No. ______________________ ☐ Home ☐ Work ☐ Cell

Address ______________________ (Please Print)

City ______________ (Please Print) State ______________ (Please Print) Zip Code ______________

E-Mail Address ______________________ (Please Print)

Remarks:

AGENT INFORMATION

I hereby authorize the Company to affix my electronic signature to all life insurance applications and related forms submitted by the undersigned. I will immediately notify the Company should this authorization for use of this signature or any prior signature authorization be terminated or revoked in any jurisdiction.

X ______________________ Signature of Agent

______________________ Date Signed

Agent Name ______________________ Agent # ______________ S.S. # _____ - ____ - _____

Telephone # ______________________ Share of Commission ______________

Additional Agent

Agent Name ______________________ Agent # ______________ S.S. # _____ - ____ - _____

Telephone # ______________________ Share of Commission ______________

Brokerage General Agent (BGA) ______________________ BGA Number ______________

Case Manager ______________ **Case Manager E-Mail Address** ______________________

DISCLAIMER

This is not an application for life insurance coverage. Signing or completing this form will in no way serve to create or commence life insurance coverage. Signing or completing this form does **NOT** mean that coverage is effective.

Please send the completed form to 3275 Bennett Creek Avenue, Frederick, MD 21704 or fax to 516-229-3084.

WILLIAM PENN LIFE INSURANCE COMPANY OF NEW YORK
A Legal & General America Company
100 Quentin Roosevelt Boulevard
Garden City, New York 11530
(800) 346-4773

Request and Authorization for Electronic Policy Delivery

Policy Owner Name ____

Proposed Insured's Name ______________________________________ Date of Birth ______________

Legal & General America is pleased to offer you the ability to receive and sign for your William Penn Life Insurance policy electronically. If your policy qualifies for electronic delivery at the time it's issued, you will receive an e-mail at the e-mail address indicated below which will provide instructions on how to electronically sign for and save/print your policy.

Please note that not all policies are available through electronic delivery, in which instance the policy would be delivered in hardcopy. Here are a few reasons why we may not be able to electronically deliver your policy.

- The Policy Owner , Proposed Insured, and Payor are not the same person.
- Application forms are incomplete or missing signatures.
- The provided e-mail is invalid.

Your privacy is important to us. At Legal & General America, we understand that the information you provide to us or we collect about you is private. We will only use your e-mail address for communication regarding your life insurance policy.

By providing your e-mail address and signing below you are indicating your consent to receive e-mail from William Penn Life Insurance Company of New York and that you wish to receive your policy through electronic delivery.

____
E-mail Address for Electronic Policy Delivery

____ ______________________
Policy Owner's Signature Date