The 1-Page Term Intake Form

Upon completion email this form to your KAFL brokerage manager. If you have questions or require assistance completing this form please contact us at (800) 272-6488 or visit www.kafl.com/contact-us.

Advisor Information:

Advisor Name:	Advisor Phone:
Advisor Email:	Date This Intake Form Was Completed:

Client Information: All Fields Are Required

Insured Name:

State of Residence	DOB:	Gender:	Marital Status:	Client Birth Country / State:

Social Security #:	Address:

City:	State:	Zip:	Primary Phone:

Driver's License State:	Driver's License #:	Driver's Licenses Exp. Date:

Client Email Address:	Best Time to Contact Client: ____ AM ____ PM

Tobacco Usage: ____ Y ____ N (if yes, indicate type of tobacco and last date of use):

Has the proposed insured ever been treated for the following? Cancer, Heart Disease, Stroke (if yes, indicate date of diagnosis) ____ Yes ____ No

Rate Class, Carrier & Product Information

Rate Class:	Type of Insurance: (Term Length):	Face Amount:

Carrier:	Product Name:
Premium Mode: _____ Annual _____ Semi-Annual _____ Quarterly _____ Monthly (EFT)	Premium Amount: $

Employment and Income Information

Is the Proposed Insured Currently Employed? _____ Yes _____ No	Employer:	Job Title:

Annual Income:	Estimated Total Assets:	Estimated Total Liabilities:	Net Worth:

Owner and Beneficiary Information

If Insured is Not Owner (Please complete): Owner is a _______ Person _______ Trust ______Corporation _______Other

Owner Information: (Name, Relationship, Address - City, State, Zip)

Primary Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %
Primary / Contingent Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %
Contingent Beneficiary Name:	SSN or TAX ID:	Relationship:	Percent: %

Replacement Information

Does the client currently own any life insurance? ____ Yes ____ No	**Please note: If this is a NY replacement an electronic application cannot be processed.** If Yes, Is this Policy Replacing any existing coverage? .____ Yes ____ No

If Client Has Existing Coverage, Provide Insurance Company(s) and Policy Number(s):

If Yes, Indicate Reason for Replacement:

What is the purpose of this insurance?: (i.e. income replacement, etc.)

Additional Information

Rider(s): _____ Waiver of Premium _____ Other (Please specify) :	Source of funds for premiums?
Has the client ever been declined, rated or postponed for life or health insurance? ___ Yes ___ No	How long have you known insured?
Did you meet with the client personally to complete this form? ____ Yes ____ No	Was an illustration presented to the insured? _____ Y _____ N

Best time and day to contact your client:

____

Best telephone to call:

____

Addtional Remarks: