

SERFF Tracking Number: BENE-125597574 State: Arkansas
Filing Company: Beneficial Life Insurance Company State Tracking Number: 38902
Company Tracking Number: LNB015 4/08
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: LNB015 4/08
Project Name/Number: LIFE APPLICATION/LNB015 4/08

Filing at a Glance

Company: Beneficial Life Insurance Company

Product Name: LNB015 4/08

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: BENE-125597574 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38902

Co Tr Num: LNB015 4/08

State Status: Approved-Closed

Co Status:

Reviewer(s): Linda Bird

Author: Shauna Burnett

Disposition Date: 05/09/2008

Date Submitted: 05/05/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: LIFE APPLICATION

Project Number: LNB015 4/08

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/09/2008

State Status Changed: 05/09/2008

Corresponding Filing Tracking Number: LNB015 4/08

Status of Filing in Domicile: Authorized

Date Approved in Domicile: 04/29/2008

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Filing Description:

The attached life application forms is a revised version of form LNB015 8/07, Part I which was previously approved. This version of Beneficial's Life Application form includes Stranger Oriented Life Insurance questions. A general marked copy has been included highlighting the changed areas. No state specific provisions are included on the marked copy. These application forms will be used with all new issues of Beneficial's life insurance products that are currently approved in your state and with forms that become approved in your state after the approval date of these application forms.

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Company and Contact

Filing Contact Information

Shauna Burnett, shauna.burnett@benfinancial.com
 150 Social Hall Avenue, 5th Floor (801) 933-1334 [Phone]
 Salt Lake City, UT 84136 (801) 531-3383[FAX]

Filing Company Information

Beneficial Life Insurance Company CoCode: 61395 State of Domicile: Utah
 150 Social Hall Avenue, 5th Floor Group Code: 615 Company Type: Life & Health
 Salt Lake City, UT 84136 Group Name: State ID Number:
 (801) 933-1335 ext. [Phone] FEIN Number: 87-0115120

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Beneficial Life Insurance Company	\$20.00	05/05/2008	20088962

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/09/2008	05/09/2008

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Disposition

Disposition Date: 05/09/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Form	LNB015 4/08		Yes

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Form Schedule

Lead Form Number: LNB015 4/08

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	LNB015 4/08	Application/LNB015 4/08 Enrollment Form	Initial		44	LNB015 4-08 .docx

SERFF Tracking Number: BENE-125597574 *State:* Arkansas
Filing Company: Beneficial Life Insurance Company *State Tracking Number:* 38902
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TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
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Attachment "LNB015 4-08 .docx" is not a PDF document and cannot be reproduced here.

<i>SERFF Tracking Number:</i>	<i>BENE-125597574</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Beneficial Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>38902</i>
<i>Company Tracking Number:</i>	<i>LNB015 4/08</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>LNB015 4/08</i>		
<i>Project Name/Number:</i>	<i>LIFE APPLICATION/LNB015 4/08</i>		

Rate Information

Rate data does NOT apply to filing.

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Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 04/07/2008
Comments:
Attachment:
LNB015 FLESCH.pdf

Review Status:

Satisfied -Name: Application 04/07/2008
Comments:
MARKED VERSION SHOWING CHANGES MADE TO CURRENTLY APPROVED APPLICATION.
Attachment:
LNB015 4-08 marked version.pdf

CERTIFICATION

I hereby certify that the following policy form(s) filed for approval by Beneficial Life Insurance Company meets the requirements of the "Flesch Reading Ease Test" as follows:

<u>Form</u>	<u>Test Scores</u>
LNB015 4/08	44.1

Dated this 1ST day of May, 2008.

Beneficial Life Insurance Company

Hardi Jenkins
Vice President – Product Management



Application for Life Insurance

PART I

Proposed Insured #1

Last Name _____ First Name _____ MI _____ Social Security # _____

Physical Address* _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Gender: Male Female Date of Birth _____ State of Birth _____

Daytime Phone # (_____) _____ Evening Phone # (_____) _____ Cell Phone # (_____) _____

E-mail Address _____ Marital Status _____ Best Contact Time _____

* Is Proposed Insured a U.S. citizen? Yes No If "no," give permanent resident visa ("green card") # _____

Driver's License # _____ State of Issue _____ If none, other I.D. # _____ / _____ / _____
Type State Number

Occupation _____ Years in Occupation _____

Employer Name _____ Years with Employer _____

Employer Address _____

Proposed Insured #2

Last Name _____ First Name _____ MI _____ Social Security # _____

Physical Address* _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

Gender: Male Female Date of Birth _____ State of Birth _____

Daytime Phone # (_____) _____ Evening Phone # (_____) _____ Cell Phone # (_____) _____

E-mail Address _____ Marital Status _____ Best Contact Time _____

* Is Proposed Insured a U.S. citizen? Yes No If "no," give permanent resident visa ("green card") # _____

Driver's License # _____ State of Issue _____ If none, other I.D. # _____ / _____ / _____
Type State Number

Occupation _____ Years in occupation _____

Employer Name _____ Years with employer _____

Employer Address _____

Complete Section for: Applicant/Owner (if other than a Proposed Insured) or Payor (if other than Owner)

Last Name _____ First Name _____ MI _____ SSN/ TIN _____

Physical Address* _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

E-mail Address _____ Daytime Phone # (_____) _____ Evening/Cell Phone # (_____) _____

Relationship to Proposed Insured _____ Date of Birth _____

Trust or Business Name _____ Date of Trust _____

Trustee(s) (list all) or Company Officer Name(s) _____

* Passport Driver's License Permanent Resident Visa Other Photo ID _____ / _____
("green card") (list type) ID No. Expiration mo / yr Country / State

Contingent Owner:

Last Name _____ First Name _____ MI _____ SSN/ TIN _____ Date of Birth _____

Physical Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____ City _____ State _____ Zip _____

* Information required per USA PATRIOT Act

Dependent Children (Complete when applying for coverage on dependent children age 17 and under of proposed insured #1 and attach an additional page as necessary.)

Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Proposed Ins. #1 _____	Height _____' _____"	Weight _____
Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Proposed Ins. #1 _____	Height _____' _____"	Weight _____
Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Proposed Ins. #1 _____	Height _____' _____"	Weight _____
Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Proposed Ins. #1 _____	Height _____' _____"	Weight _____
Name _____	Date of Birth _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relation to Proposed Ins. #1 _____	Height _____' _____"	Weight _____

Plan of Insurance

Plan Name _____ Face Amount \$ _____
 (Option A is the default if none selected for UL plans)

Option A (UL level death benefit) Option B (UL increasing death benefit)

Policy to be dated: Date Application Completed Date Policy Issued Special Date _____

Set-up Automatic Premium Loan? (Whole Life only) Yes No (If unanswered, default will be "yes.")

Riders

Term Rider \$ _____ Rider Name and # Years _____

Additional Insured Rider \$ _____ Rider Name and # Years _____

Periodic Premium PUA Rider (PPUAR), Modal Premium Amount \$ _____

Single Premium Paid-Up Additions Rider (SPUAR), Single Premium Amount \$ _____

GIO Rider \$ _____

Term Guarantee Rider (survivorship policies only) \$ _____ Rider Insured _____

Child Rider (number of units _____) Term Additions Rider \$ _____

Accidental Death \$ _____ Mission Benefit Rider

Other _____

Waiver of Premium Riders

Waiver of Monthly Deduction (UL) Limited Premium Waiver (Term)

Waiver of Specified Premium (UL), Modal Benefit \$ _____

Waiver of Premium (WL) Waiver of PPUAR, Modal Benefit \$ _____

Other _____

Comments: _____

Dividend Option (if Whole Life participating policy)

Please set up dividend option:

- | | |
|--------------------------------------|--|
| 1. _____ Paid to owner by check | 4. _____ Applied to purchase paid-up additions |
| 2. _____ Applied to Premium Due* | 5. _____ One year term* |
| 3. _____ Left on deposit at interest | 6. _____ Applied to reduce policy loan* |

*This option might not use the full dividend. Please select option 1, 3, or 4 for distribution of any remaining dividend. Mark option for the remaining dividend, if any, with a number 2. If no excess option is elected, the default option of paid-up additions will be applied.

Beneficiary Designation

Full Name	Address (include city, state, zip)	Social Security No.	Date of Birth	Relationship to Insured	% of Benefit
Primary Beneficiary(ies) Select individual(s), trust, or business entity as primary beneficiary. Benefit must total 100%					
Last					
First					
MI					
Last					
First					
MI					
Last					
First					
MI					
Last					
First					
MI					

Contingent Beneficiary(ies) Select individual(s), trust, or business entity as contingent beneficiary. Benefit must total 100%					
Last					
First					
MI					
Last					
First					
MI					
Last					
First					
MI					

- If any beneficiary named above is a minor, the proceeds will remain at interest with the Company until the minor reaches the age of majority, unless a financial guardian or conservator is appointed for the minor(s), or other distribution is legally permitted.
- If the policy provides coverage on the insured's spouse or child(ren), **unless you designate otherwise, the beneficiary designation shall be:**
 - Proceeds shall be payable upon the death of the additional insured to the Insured, if living, otherwise to the estate of the additional insured upon whose death payment is to be made.
 - Proceeds shall be payable upon the death of any child covered under the Children's Benefit to the Insured parent, if living, otherwise to the spouse of the Insured parent. If neither survive then the proceeds will be payable to the estate of the child upon whose death payment is to be made.

To designate a beneficiary other than as stated above for the Additional Insured or the Children's Benefit Rider, complete the following section. *If more than one additional insured is to be included in the policy, document the designation(s) on a separate piece of paper and attach it to this application.*

Beneficiary Designation of <input type="checkbox"/> Additional Insured <input type="checkbox"/> Children's Benefit Rider					
Last					
First					
MI					

It is understood and agreed that, unless otherwise directed, the proceeds of the policy will be paid to the Primary Beneficiary(ies) who survive(s) the insured by 15 days, but if none survive(s), the proceeds will be paid to the contingent beneficiary(ies) who survive(s) the insured by 15 days, but without liability to Beneficial Life on account of payment made before receiving at the Home Office, notice of the death of the beneficiary. If a beneficiary dies before the insured and there are other beneficiaries of the same rank, the surviving beneficiaries of that rank shall take the share of the deceased benefit unless otherwise stated above. Beneficiaries of the same rank will share equally unless otherwise stated above. The term "children" includes any natural children of the insured and legally adopted children of the insured. The right to change the beneficiary(ies) is reserved unless otherwise stated above.

Trust or Business Beneficiary Designation

Beneficial Life Insurance Company assumes no obligation under the terms of the trust beyond those assumed under the policy provisions.

Primary Contingent _____

Trust/Business Name

Address

Tax I.D. # Trust Date (if applicable) Percent of Benefit

Trustee/Company Officer Name ** Trustee/Company Officer Name **

**** List all trustees and attach a separate sheet if needed.**

In the past 3 years has any person proposed for coverage:

1. Engaged in, or intends in the future to engage in, sky or scuba diving, hang gliding, rock climbing, auto racing, motorcycle racing, powerboat racing, or any other hazardous activities?
If yes, explain _____
2. Flown, or plans to fly, as a pilot, student pilot, or crew member?
If yes, explain _____
3. Had 2 or more moving violations, been convicted of driving under the influence of alcohol, or ever had a driver's license suspended or revoked?
If yes, explain _____
4. Does any Proposed Insured plan to travel or reside outside the U.S.A.?
If yes, explain _____

Proposed Insured #1		Proposed Insured #2		Dependents	
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No

Replacement Information

Total Life Insurance or Annuities In Force:

Do you have an individual life insurance policy or annuity policy currently active with this Company or any other company? Yes No
If yes, complete Replacement Form A.

Company	Policy #	Insured Name	\$ Life Amount	\$ Accidental Death	Replaced? Y/N
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	_____

Regarding all persons proposed for insurance: (If any "yes," explain with insured and company names.)

1. Is the policy applied for to replace, change, or use funds from, any existing insurance or annuities with this or any other company? **If yes, complete Replacement Form A.**
2. Is an application pending with another company? If yes, list insured, company, and amount.

 _____ \$ _____
3. Has any person proposed for insurance ever applied for Life, Health, Long-Term Care, or Disability Insurance without receiving coverage exactly as requested (such as declined, rated, or issued with exclusions)? If yes, list insured, company, and dates, and reasons.

Proposed Insured #1		Proposed Insured #2		Dependents	
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No
Yes	No	Yes	No	Yes	No

Agent Remarks: _____

Source of Funds

1. In connection with this policy, have you discussed or contemplated the possibility of selling the policy as a life settlement? Yes No
2. Will you borrow money to pay premiums for this policy or have someone else pay these premiums for you in return for an assignment of policy values back to them? Yes No
3. Has anyone offered you a cash incentive or the promise of "free" or "no cost" life insurance for a limited period of time as an incentive to induce you to acquire this coverage? Yes No

Notice to Proposed Insured

The law requires you to be advised that in connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics, and mode of living. You have a right to access and correct the information we collect about you, except that information which relates to a claim, civil, or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please make such a request, in writing, to Beneficial Life Insurance Company, Underwriting Department, 150 Social Hall Avenue, 6th Floor, Salt Lake City, Utah, 84136.

Notice of Anti-Money Laundering Procedures

Beneficial Life Insurance Company complies with all applicable state and federal anti-money laundering laws. Like other financial institutions, we are required to report suspicious activities, large cash transactions, and persons or entities appearing on certain government lists for prohibited transactions. Government agencies may require disclosure of information, restrict release of funds, or deny any transaction suspected as illegal. Beneficial Life Insurance Company is not responsible for any resulting inconvenience, loss, or damage.

Notice of Disclosure of Information

Information regarding your insurability will be treated as confidential except that Beneficial Life Insurance Company or its reinsurers may make a brief report to the Medical Information Bureau. Upon request by another insurance company to which you have applied for life or health insurance or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files. Beneficial Life Insurance Company or its reinsurers may also release information in its file to its reinsurers and to other life insurance companies to which you may apply for life or health insurance or to which a claim is submitted. Upon receipt of a request from you, the Medical Information Bureau will arrange disclosure of any information it may have under your name. Medical information will only be disclosed to your attending physician. If you question the accuracy of information in the Bureau's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, MA 02112, telephone (617) 426-3660.

Spousal Disclosure

A spouse may sometimes have claim to a policy or to policy proceeds if joint marital assets have been used to fund the policy. This is true even if the spouse is not listed as an owner or beneficiary. State laws often presume that property is jointly owned by both spouses.

If this application names a sole owner who is currently married, the Company reserves the discretionary right to disclose all policy records to the Owner's spouse. Absent a contrary court order or signed agreement, disclosure of policy records may occur even after a divorce. If a spouse or former spouse chooses to contest incidents of policy ownership, a policy hold may be required until the dispute can be legally resolved. If the Owner wishes to be treated as the exclusive owner for all purposes of policy administration, the Owner must submit a separate authorization signed by the Owner's spouse.

Authorization to Obtain Information

- **I authorize** my physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance, or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to Beneficial Life Insurance Company or its legal representative any and all such information.
- **I understand** the information obtained by use of this Authorization will be used by Beneficial Life Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Beneficial Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.
- **I know** that I may request to receive a copy of this Authorization.
- **I agree** that a photographic copy of this Authorization shall be as valid as the original.
- **I acknowledge** receipt of the Notice of Disclosure of Information and Notice to Proposed Insured.
- **I agree** this Authorization shall be valid for twenty-four months from the date shown below.
- If an investigative consumer report is required in connection with my application, I hereby request a personal interview by checking here _____.

Dated at _____ on _____, _____.

Signature of Proposed Insured (or Parent or Guardian, if Proposed Insured is a minor)

Signature of Additional Insured

Signature of Owner (if other than Insured)

Agent's Report

1. Did you see all those to be insured on the date the application was written? If no, who was not seen and why?	Yes	No
2. Do all persons to be insured appear to be healthy? If no, explain.	Yes	No
3. Was the "Notice to Proposed Insured" given?	Yes	No
4. Was a "Temporary Insurance Agreement" given?	Yes	No
5. Does the Proposed Insured have an individual life insurance policy or annuity policy currently active with this Company or any other company? If yes, complete Replacement Form A and return with application.	Yes	No
6. Will any existing policy be changed or subjected to substantial borrowing (25% or more of tabular cash value) or withdrawals by placing this policy? If yes, complete Replacement Form A and return with application.	Yes	No
7. Will the policy applied for replace (i.e., "replace" as defined in paragraph two of Replacement Form A) or change any existing insurance or annuities with this or any other Company? If yes, complete Replacement Form A and return with application.	Yes	No
If you answered "yes" to 5, 6, or 7 above, complete 8 to 10 below.		
8. Was an original or copy of all sales material given to the applicant at the time of the application?	Yes	No
9. Was all sales material given to the applicant approved by Company?	Yes	No
10. Was a copy of all sales material logged and a copy of all individualized material submitted to the Home Office?	Yes	No
11. Is this controlled business? If yes, list relationship to agent.	Yes	No
12. Proposed Insured's annual income: \$		
13. Proposed Insured's approximate worth: \$		
14. If spouse is employed, spouse's annual income: \$		

Comments	

15. How long have you known the Proposed Insured? _____ Who introduced you? _____
 Recently met _____ (if a relative, state relationship) _____ Known well for _____ years,
 through: Business Social Other _____
 Has your customer completed the application? Yes No
 Have you personally viewed and confirmed the customer's Identification? Yes No (If passport, state issue country _____)
 16. Does this application involve an employer-owned life insurance contract? Yes No
If yes, complete an Employee Consent to Insurance form or its equivalent.

17. During the discussions with the client regarding this policy, has there been any discussion of selling the policy as a life settlement? Yes No
 18. Is this policy being funded via a premium financing loan or with funds borrowed, advanced or paid from another person or entity? Yes No
 19. Has anyone offered the client a cash incentive or the promise of 'free insurance' for a limited period of time as an incentive to purchase this insurance? Yes No
 20. Case source: Recommendation (referral) CPA Plus Current Client VST Home Office Mailing Campaign
 Personal Observation Seminar Other _____

21. References (to be obtained from applicant, if face amount is \$1 million or above):

Name _____	Address _____	Phone # _____
Name _____	Address _____	Phone # _____

Agents:
 I certify that I have truly and accurately recorded on all forms related to the application the information provided by the applicant.

Signature of Agent Making Report	Agent Name (Printed)	Agency	Date	Agent #	% of Case
	Additional Agent Name (Printed)	Agency	Date	Agent #	% of Case
	Additional Agent Name (Printed)	Agency	Date	Agent #	% of Case