William Penn
Life Insurance Company of New York
. . . A Partnership for Life
100 Quentin Roosevelt Boulevard
Garden City, New York 11530

Date of Request: _____

Request for Life Insurance Interview

*** ALL FIELDS MANDATORY**

PROPOSED INSURED

*** This program is <u>not available</u> in New York for replacement of existing insurance.**

_____ Date of Birth _____/_____/_____
(First Name, Middle, Last Name) (Month) (Day) (Year)

RISK EVALUATION

	If answer to question is not known, please leave blank. Criteria Questions			Check One Classification For Each Question
		If No...	**If Yes...**	
1	1a. Do you have a history of alcohol or substance (drug) abuse?	Check P+ and go to question 2.	Go to question 1b.	P+ P S
	1b. Has there been any abuse in the past 10 years?	Check P and go to question 2.	Check S and go to question 2.	
		If No...	**If Yes...**	
2	Have you had any DUIs in the past 2a. 5 years?	Check P+ and go to question 3.	Go to question 2b.	P+ S+ S
	2b. 3 years?	Check S+ and go to question 3.	Check S and go to question 3.	
		If No...	**If Yes...**	
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+
		If No...	**If Yes...**	
4	4a. Has either parent or a sibling had a history of cardiovascular disease or cancer before age 60?	Check P+ and go to question 5.	Go to question 4b.	P+ P S+ S
	4b. Has either parent died as a result of cardiovascular disease or cancer before age 60?	Check P and go to question 5.	Go to question 4c.	
	4c. Have both parents died as a result of cardiovascular disease before age 60?	Check S+ and go to question 5.	Check S and go to question 5.	
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
		If No...	**If Yes...**	
6	Have you used any nicotine-based products in the past 6a. 36 months?	Check P+ and go to question 7.	Go to question 6b.	P+ P S+ PT ST
	6b. 24 months?	Check P and go to question 7.	Go to question 6c.	
	6c. 12 months?	Check S+ and go to question 7.	Check PT if answers from 1 to 5 are all P/P+, otherwise, check 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.

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

Build Chart

Height	P+		P	S+	S	Height	P+		P	S+	S
	Male	Female	Male/ Female	Male/ Female	Male/ Female		Male	Female	Male/ Female	Male/ Female	Male/ Female
5'0"	144	135	158	166	172	6'0"	207	180	228	240	249
5'1"	148	138	163	172	178	6'1"	213	184	234	245	255
5'2"	153	140	168	175	183	6'2"	219	188	241	253	263
5'3"	158	143	174	182	190	6'3"	225	193	247	259	269
5'4"	163	145	179	188	195	6'4"	230	197	253	265	276
5'5"	168	148	185	194	202	6'5"	237	201	260	272	283
5'6"	174	150	191	200	208	6'6"	243	205	267	280	291
5'7"	179	155	197	206	215	6'7"	249	209	274	287	299
5'8"	185	160	203	212	221	6'8"	256	214	281	294	306
5'9"	190	165	209	219	228	6'9"	262	218	288	302	314
5'10"	196	170	215	226	234	6'10"	268	222	295	309	322
5'11"	201	175	221	231	241	6'11"	276	226	303	317	330

Proposed Insured _____

PROPOSED INSURED INFORMATION

Quoted Premium $ _____ Face Amount $ _____

Product (Please check only one.)

Penn Term ☐ 10 ☐ 15 ☐ 20 ☐ 30

Life Value Term ☐ 20 ☐ 30

Life Choice UL ☐ Life Change UL ☐

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 (Replacements not available in New York for AppAssist cases.)

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

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

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

(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.

PrimaryTelephone 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 _____

Organization or Broker/Dealer that Agent Represents _____

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 100 Quentin Roosevelt Boulevard, Garden City, NY 11530 or fax to 516-229-3084.