DEPARTMENT OF LABOR AND REGULATION

DIVISION OF INSURANCE

SAMPLE APPLICATION FORM

Chapter 20:06:06

APPENDIX B

SEE: § 20:06:06:11

**Source:** 32 SDR 203, effective June 5, 2006.

**APPENDIX B**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Insured Debtor | | | John Doe Box 555 Anywhere, USA, 55555 | | | | Date of Birth | | | | Age | | Certificate Number | | | | | | | | | |
| Joint Insured Debtor | | | | | | |  | | | |  | |  | | | | | | | | | |
| Creditor (Beneficiary) (Name and Address) | | | ABC Bank 555 AVENUE Anywhere, USA 55555 | | | | | | | | Creditors Insurance Account No | | | | | | | | | | | |
| Assignee (Name and Address) | | | | Monthly Payment | | | | | | | Annual Simple Interest Rate | | | | | | | | | | | |
| Second Beneficiary | | | | | | | | | | | Relationship | | | | | | | | | | | |
| EFFECTIVE DATE | | | | EXPIRY DATE | | | | | | | Days to 1st Payment | | | | | | | | | | | |
| COVERAGES | | | | | | | | | | | INITIAL AMOUNT OF INSURANCE | | | | PREMIUMS | | | | TERM IN MONTHS | | | |
| □ Gross or | □ NET | | | | □ W. Dism | □ W/O Dism | | | | |
| □ Decreasing Term |  | | | | □ Periodic Decreasing Term | | | | | | $ 5,400.00 | | | | $ - | | | | 36 | | | |
| □ Jt. Decreasing Term |  | | | | □ Jt. Periodic Decreasing Term | | | | | |  | | | |  | | | |  | | | |
| □ Level Term |  | | | | □ Jt. Level Term | | |  | | | $ 11,197.00 | | | | $ - | | | | 36 | | | |
| 35 | Payments of $ | | | | $150.00 | | |  | | | $ 5,400.00 | | | | $ - | | | | 36 | | | |
|  | Final Payment of $ | | | | $11,347.51 | | |  | | | [$150.00 Monthly Disability Benefit] | | | | $ - | | | | PREMIUM ←TOTAL | | | |
| □ Disability Coverage (Insured Debtor Only) | | | | | | | | | | |
|  | | |  |  | |  | | | | |
| WAITING PERIOD ELIMINATION PERIOD | | | |  | |  | | | | |
| □ 7 Days | | | Retrospective | 0 Days | |  | | | | |
| □ 14 Days | | | Retroactive | 0 Days | | Maximum Monthly Disability (per debtor) | | | | | Maximum Monthly Disability (per debtor) | | | | Maximum Term | | | | **Maximum Issue Age 65 Inclusive** | | | |
| □ 30 Days | | | Retroactive | 0 Days | |
| □ 14 Days | | | Non-Retro | 14 Days | |
| □ 30 Days | | | Non-Retro | 30 Days | |
|  | | |  |  | | $1000.00 (Ages 18-65) | | | | | $100,000.00 Ages 18-65) | | | | 120 Months | | | |
|  | | |  |  | |
|  | | |  |  | |  | | | | |  | | | |  | | | |  | | |  |
| DEATH CLAIM STATEMENT- INSTRUCTIONS: Creditor Policyholder should complete the statement below and return with the following documents: 1. Certified copy of the Death Certificate showing cause of death; 2. Copy of the conditional sales contract or note covered by the Insurance; 3. Copy of the Policy or Certificate Issued to the deceased. This completed form, together with the documents specified above, should be sent to: | | | | | | | | | | | | | | | | | | | | | |  |
|  |
| ABC ASSURANCE COMPANY Insurance Division, 555 Boulevard, Anywhere, USA, 55555-555 | | | | | | | | | | | | | | | | | | | | | |  |
|  | | |  |  | |  | | |  | | | |  | | | | |  | | | |  |
| 1. Name of Insured | | | | | | | | | | | | | | | | | | | | | |  |
| 2. Certificate No. (or individual Policy No.) | | | | | | Date of Loan | | | |  | | | | for Term of | | | Mos. | | | | |  |
| 3………………………………… | | Original Amount Insured | | ……………………………. | | $ - | | | |  | | | |  | | |  | | | | |  |
| 4………………………………… | | Less Amount Paid | | ……………………………. | | $ - | | | | To comply with certain State Laws, our payoff to a creditor may be for the net amount due (Gross amount less unearned interest and/or advance payments). Please advise us of this amount. Any remaining balance is payable to the second beneficiary if named, otherwise to the Debtors Estate. | | | | | | | | | | | | |
| 5………………………………… | | Less Unearned Interest | | ……………….………… | | $ - | | | |
| 6………………………………… | | Less Unearned A & H Premium (Life Premium Earned) | | …………………………… | | $ - | | | |
| 7………………………………… | | Balance Due | | …………………………… | | $ - | | | |
| 8…………………………………. | | Number of Monthly Payments in Default at Death | | | |  | | | |  | | |  | | | | |  | |  | | |
| 9…………………………………. | | Creditor Policyholder's Name | | | | | | | | "Insurance Account No." | | | | | | | | | |  | | |
| Street Address | | | | | | | City | | | State | | | Zip Code | | | | |  | |  | | |
| I hereby certify that the above answers are complete and true, and the balance due is the amount in line 7. | | | | | | | | | | | | | | | | | | | |  | | |
| Date: | | | | By: | | | | | Title: | | | | | | | | | | |  | | |
|  | | |  |  | | |  | |  | | | |  | | | | |  | |  | | |
| **PREMIUM REFUND RECEIPT SCHEDULE** | | | | | | | Send to: P.O. Box 555 Anywhere, USA 55555-555 | | | | | | | | | | | | |  | | |
|  | | | MO. | DAY | | | YEAR | |  | | | LIFE | | | | DISABILITY | | | | TOTAL | | |
| DATE OF CANCELLATION | | |  |  | | |  | | PERCENT UNEARNED | | | % | | | | % | | | |  | | |
|  | | |  |  | | |  | |  | | |  | | | |  | | | |  | | |
| POLICY CERTIFICATE WAS IN FORCE | | |  | MONTHS | | |  | | AMOUNT OF REFUND | | | % | | | | % | | | |  | | |
| I understand, hereby request cancellation of the above numbered certificate or policy as of 12:00 noon, Standard Time, as of the date of cancellation shown above. I hereby acknowledge receipt of the amount of refund shown above as a full refund of the unearned portion of the premium and hereby release ABC Company from all further liability under said certificate (s) or policy(ies)) as the case may be | | | | | | | | | | | | | | | | | | | |  | | |
|  | | |  |  | | |  | |  | | | |  | | | | |  | |  | | |
|  | | |  |  | | | Date | | | | | |  | | | | | | | | | |
| AGENT OR WITNESS | | | | | | |  | |  | | | | SIGNATURE OF INSURED | | | | | | | |  | |
|  | | |  |  | | |  | |  | | | |  | | | | |  | | |  | |
| Name of Creditor | | | | | | | Address | | | | | | | | | | | | | | | |