POLICY ASSESSMENT

Client Worksheet

Advisor Information:	
Advisor's Name:	**Phone #:**
Advisor's Firm/Company:	**Email:**

Section B: Policy Objectives Please choose "P" for "Primary" or "S" for "Secondary".		
☐ P / ☐ S **Increase Guarantee(s)**	☐ P / ☐ S **Reduce Annual Premium**	☐ P / ☐ S **Combine Policies**
☐ P / ☐ S **Increase Face Amount**	☐ P / ☐ S **Reduce Years to Pay**	☐ P / ☐ S **Other**
☐ P / ☐ S **Provide Living Benefits**	☐ P / ☐ S **Generate Income**	**Please describe:**

Section 1: Client Information	
Client #1 Name:	**Client #2 Name:**
Date of Birth:	**Date of Birth:**
Sex: ☐ **M** / ☐ **F** **Height:** _____ **Weight:** _____	**Sex:** ☐ **M** / ☐ **F** **Height:** _____ **Weight:** _____
Have you ever used nicotine products? ☐ **Yes** / ☐ **No**	**Have you ever used nicotine products?** ☐ **Yes** / ☐ **No**
☑ If yes, what type/date of last usage:	☑ If yes, what type/date of last usage:

Section 2: Client Health Information	Client #1	Client #2
Have you ever been treated for any of the following conditions? (Check all that apply):	☐ Cancer (Type: _____) ☐ Diabetes ☐ Heart Disease ☐ Kidney / Liver Disease ☐ Vascular Disease ☐ Other: _____	☐ Cancer (Type: _____) ☐ Diabetes ☐ Heart Disease ☐ Kidney / Liver Disease ☐ Vascular Disease ☐ Other: _____

Section 3: Medications					
	Medication Name (i.e. Aspirin)	**Dosage** (i.e. 81mg)	**Frequency** (i.e. 1x Daily)	**Date Prescribed**	**Reason for Taking** (i.e. Heart Maintenance)
Client #1					
Client #2					

Fax to: (916) 773-4484 or (888) 678-8376

AUTHORIZATION FOR RELEASE OF IN-FORCE POLICY INFORMATION

I hereby authorize Pinney Insurance Center, Inc., and its staff, to obtain and/or request information regarding my existing life insurance policy(s) listed below. This information shall include but not be limited to: in-force ledgers, policy dates, cash value information, interest/dividend history, and underwriting classifications.

Insured	SS# or T.I.N.	Insurance Carrier	Policy Number	Issue Date	Policy Type

The information above will be held in confidence. The policy data collected may be reviewed and assessed by qualified personnel consisting of medical, underwriting, and actuarial resources or other related employees involved in the submission, receipt or evaluation of insurance applications or prospective applications of Pinney Insurance Center, Inc., affiliated insurance companies, and their reinsurers.

The records may be transmitted via U.S. regular mail, various overnight mail services, and/or through the use of secured electronic devices.

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 revoke this authorization at any time and that the revocation will take effect when my Representative receives my written request.

PA-CW 2.3.12

Please provide the following for the above mentioned policy or policies, based on current assumptions:

[1] In-force illustration at current premium schedule
[2] In-force illustration with minimum premium to endow
[3] In-force illustration with minimum premium to guarantee to maturity
[4] Policy Cost Basis
[5] Other:_____

Please forward the requested information to:

PINNEY Insurance Center
2266 Lava Ridge Court
Roseville, CA 95661
Fax: (916)481-2580

Signed on the _____ day of _____, the year _____ at _____
(day) (month) (year) (city and state)

_____ _____
Owner Signature(s)/ Trustee Signature(s): **Owner Signature(s)/ Trustee Signature(s):**

_____ _____
Owner Signature(s)/ Trustee Signature(s): **Owner Signature(s)/ Trustee Signature(s):**

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