

# POLICY ASSESSMENT

## Client Worksheet

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

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

Section 1: Client Information	
Client #1 Name:	Client #2 Name:
Date of Birth:	Date of Birth:
Sex: <input type="checkbox"/> M / <input type="checkbox"/> F    Height: _____ Weight: _____	Sex: <input type="checkbox"/> M / <input type="checkbox"/> F    Height: _____ Weight: _____
Have you ever used nicotine products? <input type="checkbox"/> Yes / <input type="checkbox"/> No	Have you ever used nicotine products? <input type="checkbox"/> Yes / <input type="checkbox"/> No
<input checked="" type="checkbox"/> If yes, what type/date of last usage:	<input checked="" type="checkbox"/> If yes, what type/date of last usage:

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

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

## 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):