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 |