INSURANCE REVIEW SERVICES

Long-Term Care & Life Insurance | Client Application & Planning Checklist

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Please click any highlighted field and type your information. Click checkboxes to mark them.

1 - PERSONAL INFORMATION

Full Legal Name			
Date of Birth		Age	
Place of Birth		Gender	
U.S. Citizen / Permanent Resident			
Social Security Number			
Home Address			
City, State, ZIP (full 9-digit)			
Day Phone		Mobile Phone	
Business Phone			
Email Address			
Marital Status			
Occupation and Duties			
Employer Name			
Gross Annual Income		Approximate Net Worth	
Driver's License Number		Driver's License State	
Driver's License Copy Submitted	☐ On File		

2 - OWNERSHIP & BENEFICIARY INFORMATION

Policy Ownership & Premium Payor

Proposed Policy Owner			
Proposed Premium Payor			
Trust-Owned Policy? (Y/N)		Trust Name and Date	
Trustee Name(s) and Contact Information			
Existing ILIT or Estate Planning Documents			

Primary Beneficiary

Full Name			
Relationship to Insured		Date of Birth	
Social Security Number		Designation %	
Address			
Email Address			

Contingent Beneficiary #1

Full Name			
Relationship to Insured		Date of Birth	
Social Security Number		Designation %	
Address			

Contingent Beneficiary #2

Full Name			
Relationship to Insured		Date of Birth	
Social Security Number		Designation %	
Address			

3 - EXISTING INSURANCE COVERAGE

Life Insurance (Please Provide Copies)

Policy schedule / face page	☐ On File
Annual statements (most recent)	☐ On File
Current premium notices	☐ On File
In-force illustrations	☐ On File
Conversion deadlines on term policies	☐ On File
Existing riders and living benefits	☐ On File

Long-Term Care Insurance (Please Provide Copies)

Existing LTC policy documents	☐ On File
Benefit summaries	☐ On File
Inflation rider details (simple vs. compound)	☐ On File
Monthly benefit amounts (original and current)	☐ On File
Elimination period	☐ On File
Claims history (if any)	☐ On File

Disability & Business Insurance

Individual disability policy	☐ On File
Employer-sponsored disability (STD / LTD)	☐ On File
Buy-Sell funding arrangements	☐ On File
Key Person insurance	☐ On File
Executive benefit plans	☐ On File

4 - MEDICAL INFORMATION

Height		Weight	
Tobacco / Nicotine Use - Current (Y/N)			
Tobacco history (type, amount, quit date)			
Primary Physician Full Name			
Physician Address			

Physician Phone | Date of Last Medical Visit

Reasons and Findings of Last Visit

Current Prescription Medications

Major Illnesses / Surgeries / Hospitalizations

Family Medical History (if requested)

Pending Medical Testing or Consultations

Planned Physician Visits (next 90 days)

5 - LONG-TERM CARE PLANNING INFORMATION

Caregiving & Family History

Current caregiving responsibilities

Family history of dementia / Alzheimer's

Prior long-term care claims history

Preferred Care Setting (Check All That Apply)

- [ ] Home Care
- [ ] Assisted Living
- [ ] Skilled Nursing Facility
- [ ] Cash Indemnity Benefits

Long-Term Care Coverage Goals

Monthly benefit amount desired

Benefit duration (6 Yrs / 10 Yrs / Lifetime)

Inflation protection (simple / compound)

Shared benefits for couples (Y/N)

Legacy / death benefit objective

Protect retirement assets from LTC costs? (Y/N)

6 - FINANCIAL INFORMATION

Gross Annual Income

Spouse / Partner Annual Income

Other Income Sources

Approximate Net Worth

Employer Group Life Insurance Coverage

Bank / ACH Information for Premium Draft

Financial Documents (Provide If Required by Underwriter)

Tax Returns (most recent 2 years)	☐ On File
W-2s or K-1s	☐ On File
Brokerage / Investment Statements	☐ On File
Personal Financial Statement	☐ On File
Trust Documents	☐ On File
Business Financial Statements	☐ On File
Estate Planning Documents	☐ On File

7 - BUSINESS & TRUST PLANNING

Trust-Owned Policy? (Y/N)	
Copy of Trust Documents	
Buy-Sell Agreement	
Ownership Structure Details	
Entity Type (C-Corp / S-Corp / LLC / Partnership)	
Key Executive Information	
Existing Business Insurance Arrangements	

8 - PLANNING CONSIDERATIONS

Existing Irrevocable Life Insurance Trust (ILIT)	☐ On File
Special Needs Trust	☐ On File
Estate tax concerns	☐ On File
Asset protection concerns	☐ On File
Charitable planning goals (CRT, DAF, bequest)	☐ On File
Business succession planning	☐ On File
Executive compensation plans (162 bonus, SERP, NQDC)	☐ On File
Protect retirement assets from long-term care costs	☐ On File

9 - INSURANCE PLAN INFORMATION

Plan / Product Name	
Insurance Carrier	
Initial Death Benefit / Coverage Amount	
Premium Payment Frequency	
Estimated Annual Premium	
Risk Class	
Table Rating (if applicable)	
Application Signed State	
Electronic Policy Delivery? (Y/N)	
Electronic Medical Interview? (Y/N)	

Riders (Please Indicate Interest)

☐ Children's Term Rider

- [ ] Accidental Death Benefit Rider
- [ ] Income Provider Option
- [ ] ExtendCare / LTC Accelerated Benefit Rider
- [ ] Chronic Illness Accelerated Death Benefit Rider
- [ ] Critical Illness Rider
- [ ] Disability Benefit Rider
- [ ] Waiver of Premium

10 - UNDERWRITING REQUIREMENTS

Telephone Interview	☐ On File
Cognitive Assessment	☐ On File
Paramedical Examination	☐ On File
Blood and Urine Testing	☐ On File
APS (Attending Physician Statement)	☐ On File
Prescription Database Review	☐ On File
Medical Records Review	☐ On File
Financial Verification	☐ On File
Replacement Policy Information	☐ On File

11 - AGENT & SUBMISSION INFORMATION

Primary Agent Name	Withbert W. Payne, CPA, CGMA, FCA
Agent Address	3150 Crow Canyon Place, Suite 100, San Ramon, CA 94583
Agent Phone	925.708.6501
Agent Email	withbert.payne@insurance-review-services.com
CA Insurance License No.	0E90257
Carrier Tracking / Application Number	
Application Signed State	
Information Submitted Date	
Additional Agents (if any)	

12 - SPOUSE / CO-APPLICANT INFORMATION

Complete this section only if a spouse or partner is also applying or if joint / shared LTC coverage is being considered.

Full Legal Name			
Date of Birth		Place of Birth	
U.S. Citizen / Permanent Resident			
Social Security Number			
Home Address (if different)			
Mobile Phone		Email Address	
Occupation and Duties			
Employer Name			

Gross Annual Income | Driver's License Number

Driver's License State

Driver's License Copy Submitted ☐ On File

Spouse / Co-Applicant Medical Information

Height | Weight

Tobacco / Nicotine Use - Current (Y/N)

Tobacco history (type, amount, quit date)

Primary Physician Full Name

Physician Address

Physician Phone | Date of Last Medical Visit

Reasons and Findings of Last Visit

Current Prescription Medications

Major Illnesses / Surgeries / Hospitalizations

Pending Medical Testing or Consultations

Planned Physician Visits (next 90 days)

Spouse / Co-Applicant LTC Coverage Goals

Monthly benefit amount desired

Benefit duration (6 Yrs / 10 Yrs / Lifetime)

Inflation protection (simple / compound)

Shared benefit rider with primary? (Y/N)

Preferred care setting (Home / AL / SNF / Cash)

Legacy / death benefit objective

13 - LIFE INSURANCE NEEDS ANALYSIS

Income Replacement

Annual income to be replaced

Years of income replacement needed

Spouse / partner income (if applicable)

Other household income sources

Age when income replacement ends

Outstanding Debts & Obligations

Primary mortgage balance

Second mortgage / HELOC

Auto loans

Student loans (self or children)	
Credit card / consumer debt	
Business loans / obligations	
Other outstanding liabilities	

Education & Future Goals

Number of children / dependents	
Education funding goal per child	
Years to college (youngest child)	
529 / education savings in place (Y/N)	
Charitable or legacy bequest goal	

Existing Assets & Coverage (To Offset Need)

Life insurance in force (total face amount)	
Liquid savings / emergency fund	
Investment / brokerage accounts	
Retirement accounts (IRA, 401k, pension)	
Real estate equity	
Social Security survivor benefit estimate	
Spouse / partner life insurance in force	

Coverage Objectives

Coverage objective (income / debt / estate)	
Term coverage desired (10/15/20/25/30 yr)	
Permanent coverage interest (Whole / UL / IUL)	
Target death benefit amount	
Budget / maximum premium comfortable with	
Preferred premium payment frequency	
Living benefits important? (chronic / critical)	
Second-to-die / survivorship policy interest	

14 - CONTACT, LIFESTYLE & TRAVEL

Best Time & Method to Contact You

Preferred contact method (call / text / email)	
Best time to reach you	
Specific preferred time / time zone	
Secondary contact name and relationship	
Secondary contact phone / email	

Aviation

- [ ] Private pilot - single engine

- [ ] Private pilot - multi-engine
- [ ] Commercial / airline pilot
- [ ] Helicopter pilot
- [ ] Ultralight / experimental aircraft

High-Risk Sports & Activities

- [ ] Skydiving / parachuting
- [ ] Scuba diving
- [ ] Rock / mountain climbing
- [ ] Hang gliding / paragliding
- [ ] Base jumping
- [ ] Motorcycle / motocross racing
- [ ] Auto / boat racing
- [ ] Bungee jumping
- [ ] Cave diving / spelunking
- [ ] Other high-risk activity (describe below)

International Travel

Countries visited in the last 12 months	
Countries to visit in the next 24 months	
International travel frequency (trips/year)	
Average duration per trip	
Travel to high-risk areas (conflict zones)	
Purpose of travel (business / personal / medical)	

Military Service

Current or recent military service? (Y/N)	
Branch and rank	
Active duty / reserve / retired	
Deployed to combat zone (last 3 years)? (Y/N)	
Deployment expected in the next 12 months?	

15 - SOCIAL SECURITY & RETIREMENT PLANNING

Social Security

Currently receiving Social Security? (Y/N)	
If yes - monthly benefit amount	
Estimated SS benefit at full retirement age	
Full Retirement Age (FRA)	
Planned SS claiming age	
Spouse SS benefit (if applicable)	
Survivor benefit considerations	

SS statement reviewed recently? (Y/N)	

Pension & Defined Benefit Plans

Pension / defined benefit plan? (Y/N)	
Employer / plan name	
Estimated monthly pension benefit	
Pension start date / eligibility age	
Survivor / joint-life option elected?	
Cost-of-living adjustment (COLA) included?	

Retirement Accounts (IRA, 401K, 403B, SIMPLE, SEP)

Total retirement account balance (approximate)	
Annual contributions (current)	
Employer match (if applicable)	
Roth vs. Traditional split (approximate %)	
RMD (Required Minimum Distribution) reached? (Y/N)	
Annual RMD amount (if applicable)	
Annuity income from retirement accounts?	

Retirement Income & Goals

Target retirement age	
Desired monthly retirement income	
Estimated monthly retirement expenses	
Estimated retirement shortfall / surplus	
Concern about outliving assets? (Y/N)	
LTC cost risk to retirement savings? (Y/N)	
Guaranteed lifetime income desired? (Y/N)	
Estate / inheritance goal for heirs	
Other advisors (planner, CPA, attorney)	

16 - INSURER COMPARISONS

Completed by Insurance Review Services following our independent multi-carrier analysis.

Life Insurance - Carrier Comparison

Feature / Criterion	Carrier 1	Carrier 2	Carrier 3	Carrier 4
Carrier / Insurer Name				
AM Best Rating				
Product Name				
Product Type (Term / UL / IUL / WL)				
Term Length (if applicable)				
Death Benefit Amount				
Annual Premium				

Monthly Premium				
Risk Class Quoted				
Guaranteed Period				
Conversion Privilege? (Y/N)				
Chronic Illness Rider Available?				
Critical Illness Rider Available?				
LTC / ExtendCare Rider Available?				
Exam Required?				
Recommendation? (Y/N)				
Notes / Comments				

Long-Term Care Insurance - Carrier Comparison

Feature / Criterion	Carrier 1	Carrier 2	Carrier 3	Carrier 4
Carrier / Insurer Name				
AM Best Rating				
Product Type (Traditional / Hybrid / Asset-Based)				
Monthly Benefit Amount				
Benefit Period (years or lifetime)				
Elimination Period (days)				
Inflation Protection (simple / compound / none)				
Shared Benefit Rider Available?				
Home Care Coverage Included?				
Cash Indemnity Option?				
Annual Premium (individual)				
Annual Premium (couple, if applicable)				
Death Benefit (hybrid / asset-based)?				
Tax-Qualified Plan? (Y/N)				
Recommendation? (Y/N)				
Notes / Comments				

Disability Insurance - Carrier Comparison (If Applicable)

Feature / Criterion	Carrier 1	Carrier 2	Carrier 3	Carrier 4
Carrier / Insurer Name				
Own-Occupation Definition? (Y/N)				
Monthly Benefit Amount				
Benefit Period (years / to age 65 / lifetime)				
Elimination Period (days)				
Non-Cancelable / Guaranteed Renewable?				
Annual Premium				
Recommendation? (Y/N)				

Recommendation Summary

Life Insurance

Long-Term Care

Disability

Additional Notes

CLIENT ACKNOWLEDGEMENT & SIGNATURE

I understand that underwriting approval and premiums are subject to insurer review, medical underwriting, and financial qualification. The information I have provided is true and complete to the best of my knowledge.

Type your full legal name as your electronic signature:

Full Legal Name (Electronic Signature)

Date:

MM / DD / YYYY

☐ By checking this box, I confirm that my typed name above is my legal electronic signature.