



Gerber Life  
Insurance

## Gerber Life | Gerber Life College Plan

### Agent Instruction for Submitting New Application

In addition to the insurance application, the following forms may be required at time of application and should be submitted at the same time as the application:

**Supplement to an Application for Individual Endowment Policy**-if owner is different than insured

**Replacement Form**<sup>1</sup> - If Gerber Life policy will replace another policy, complete appropriate state required form. Form must be submitted with application.

**NAIC-Replacement Sales/Marketing Materials Form** - In compliance with the NAIC Model Replacement Act, if the Gerber Life policy will replace another policy, the Replacement Sales/Marketing form must be completed.

Commissions will be withheld until the document is received.

**Payment Authorization Form**- For automatic payment from Checking or by Credit Card, complete ACH-AP form.

**NOTE:** When setting up payments to be withdrawn, specific draft dates for the first payment cannot be honored.

Once first payment has drafted after issuance of policy, the agent or customer can call in to change the bill date for future drafts. **Checks and money orders not accepted at time of application for this product.**

\*In KS if authorization of payment is collected with the application, please provide the Temporary Insurance Receipt TIR-2015-KS to customer and submit a copy of the receipt with the application and payment. The receipt must be signed by the agent.

**Split Commissions** - Split commissions are allowed between 2 agents. Check off Agent Split near the upper right-hand corner of the application. Fill out the Agent Split Request Form located in this kit.

**(CA Only) Disclosure to Seniors** - If individual is age 65 or older and agent is meeting in their home, provide completed form to individual. A copy should be kept on file (Do Not send to Gerber Life).

**(NY Only) Definition of Replacement** - Replacements are not allowed in New York, although the Definition of Replacement form must be filled out for all life insurance applications. The document must be signed by the Applicant and the Agent, and a copy left with the Applicant. This document must be returned to the Company with the application. The signed date on the form must be the same signed date as the application.

**(NY Only) I Certify Form** - In compliance with NY state law, submission of the completed 'I Certify Form' is required to be sent with your application packet verifying your adherence to NY PIF and BG process. Commissions will be withheld until the document is received.

**(NY Only) Agent Best Interest Certification** - In compliance with NY Regulation 187, it is required that agents act in their customers best interest. This form is a certification that the product selected is in the best interest of the customer. This form must be signed and submitted with all NY applications. Failure to comply will result in the application being closed out.

**(NY Only) Producer Checklist** - In compliance with NY Regulation 187, agents are required to retain documentation related to recommendations made to a customer regarding life insurance products. This form is for your records only and is not to be submitted with applications.

**(NY Only) Life Suitability and Best Interest Questionnaire** - In compliance with NY Regulation 187, agents are required to determine the suitability of a product(s), prior to making a recommendation to the customer. This questionnaire is required to establish product suitability in accordance with the NY Regulation 187. One form is required per policy and is owner specific (*you cannot list multiple insureds on one questionnaire.*) This form is required to be completed in full and failure to comply will result in the application being closed out.

• Please follow your Marketing Office procedures for application submission to Gerber Life.

<sup>1</sup> Replacements are not accepted in following states: CA, DE, FL, ID, IL, KY, MA, NY, PA, PR, TN, WA

## Application for Individual Endowment Policy

Gerber Life Insurance Company 1311 Mamaroneck Avenue, White Plains, NY 10605

Select Amount: ☐ \$10,000 ☐ \$25,000 ☐ \$50,000 ☐ \$100,000 ☐ \$150,000 ☐ Other \_\_\_\_\_ (enter amount between \$10,000 and \$150,000)Select Maturity: ☐ 10 Years ☐ 15 Years ☐ 18 Years ☐ Other \_\_\_\_\_ (enter number between 10-20)Select Payment Type: ☐ Installment Payments (Premiums)

SEND NO MONEY NOW!

**INSURED** Must be at least 18 years oldFull Name \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_ Preferred Telephone Number ( ) \_\_\_\_\_

Sex \_\_\_\_\_ Height \_\_\_\_\_ ft. \_\_\_\_\_ in. \_\_\_\_\_ Weight \_\_\_\_\_ lbs. \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Month Day Year)

Occupation \_\_\_\_\_ If none, source of income \_\_\_\_\_

☐ Check box if owner is different from insured. If different please provide Full Name \_\_\_\_\_  
(Last) (First) (Middle Initial)**BENEFICIARY:** Please enter the name of the person to receive benefits if you, the insured, die before policy maturity:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

- 1) In the past 5 years, have you: been hospitalized or consulted with or examined or treated by any doctor or health facility?  
(You do not need to include colds, minor viruses, or minor injuries which prevented normal activities for a period of less than 5 days or normal pregnancy or childbirth.) ..... ☐ Yes ☐ No
- 2) In the past 5 years, have you: been advised by a member of a medical profession to reduce the use of alcohol or to seek treatment for the use of alcohol or drugs, or used any controlled substance except as prescribed by a physician? ..... ☐ Yes ☐ No
- 3) In the past 5 years have you plead guilty to or been convicted of a felony or misdemeanor, or do you have such a charge currently pending against you or are you currently on probation or parole? ..... ☐ Yes ☐ No
- 4) In the past 10 years, have you been treated or diagnosed by a member of a medical profession for a disease, disorder or condition below:
- |   |  |                              |  |                            |  |
|---|--|------------------------------|--|----------------------------|--|
| Heart. ....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes. ....               | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure. ....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mental or Nervous Disorder. ....                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney ....                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver ....                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung. ....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer or Tumor ....         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Lymph Nodes ....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke. ....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood (except "HIV status"). | <input type="checkbox"/> Yes <input type="checkbox"/> No | Brain, Spine, Nerves. .... | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach ....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Intestines. ....             | <input type="checkbox"/> Yes <input type="checkbox"/> No |                            |  |
| AIDS (Acquired Immune Deficiency Syndrome) .... | <input type="checkbox"/> Yes <input type="checkbox"/> No |                              |  |                            |  |

Give full details if you answered "Yes" to any question above and list each condition. (Use and sign separate sheet if necessary.)

Nature of Condition	When Condition Started	Do you still have the condition?
		<input type="checkbox"/> Yes <input type="checkbox"/> No

- 5) Do you have any existing life insurance or annuity contract? ..... ☐ Yes ☐ No  
If yes, please complete the information below.

Company Name	Amount	Policy #	Year Issued

- 6) Will any life insurance or annuity policy be replaced, changed or used to pay for the insurance applied for in this application? ... ☐ Yes ☐ No

**It is understood and agreed that:**

All statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

I authorize any physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, or consumer reporting agency that has any records or knowledge of me or my health or mental condition, general character and driving records, to give such information to Gerber Life, its reinsurers, or other persons performing business or legal services in connection with my application for insurance. I authorize Gerber Life Insurance Company or its reinsurer to make a brief report of my personal health information to MIB Inc. (MIB). In addition, I authorize the Medical Information Bureau (MIB) to release to Gerber Life Insurance or its reinsurers any information within its records pertaining to me or my health. I understand the information obtained by use of this Authorization will be used by Gerber Life to determine my eligibility for insurance. To facilitate rapid submission of such information, I authorize all said sources (with the exception of MIB) to give such information to any agency employed by Gerber Life to collect and transmit it. A photographic copy of this authorization shall be as valid as the original. I agree this Authorization shall be valid for 24 months from the date shown below, and that upon my request I have a right to receive a copy of this Authorization.

**X**

Insured's Signature \_\_\_\_\_ City/State \_\_\_\_\_ Date \_\_\_\_\_



**Gerber Life Insurance**

445 State Street • Fremont, Michigan 49412  
www.gerberlife.com

# Agency Application

**Agent Name** \_\_\_\_\_ **Agency Name** \_\_\_\_\_ **Agent #** \_\_\_\_\_

**Agent Phone #** \_\_\_\_\_ **Agent Email** \_\_\_\_\_ ☐ **Agent Split**

## Replacement Questions to be answered by Agents:

1) Does the proposed insured have any existing life insurance or annuity contracts? ..... ☐ **Yes** ☐ **No**

2) Has any life insurance or annuity contract either in force or applied for on the proposed insured terminated or is termination of such insurance contemplated as a result of the insurance of the life insurance contract applied for? ..... ☐ **Yes** ☐ **No**

If the answer to either question is yes, have you complied with the requirements of the Company and your state with regard to this replacement? ☐ **Yes** ☐ **No** (Give full details under Remarks.)

Remarks: \_\_\_\_\_

\_\_\_\_\_  
Agent Signature

## ADDITIONAL INFORMATION

### MIB, Inc. (Medical Information Bureau)

Information regarding your insurability will be treated as confidential. Gerber Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Gerber Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

MIB-14

### Your Rights under the Fair Credit Reporting Act

Depending on the size of the policy applied for, we may request that an investigative consumer report about the Proposed Insured be given to us. It will be conducted by a national organization skilled in obtaining information about people. A credit report may be requested in connection with this application to determine eligibility of insurance or premium to be charged.

The kind of information we may be seeking includes such facts as residence verification, marital status, occupation, general reputation, personal characteristics and mode of living. It will be obtained through personal interviews with the Proposed Insured's friends,

neighbors, associates and other acquaintances. Inquiries will not be directed toward determining the Proposed Insured's sexual orientation.

The Proposed Insured, upon written request, will be informed whether or not an investigative report was requested, and if a report was ordered, the name and address of the Consumer reporting agency. A copy of this report is available to the Proposed Insured upon request.

The following notice applies to applicants in the states of AZ, CA, CT, GA, IL, ME, MA, MN, MT, NJ, NV, NC, OH, OR, and VA: To approve your insurance and service your policy, we may collect or disclose information about you, as permitted by law, which may include certain disclosures made without your prior authorization. You have the right to access and correct personal information that we have about you. You may also receive a detailed notice on Gerber Life's Information Practices, upon request.

### Benefits, Exclusions and Limitations

No physical exam is necessary in most cases. Coverage is dependent on answers to health questions, and a physical may be necessary for applicants age 51 and older and applying for more than \$100,000 of coverage. If the insured dies by suicide within two years from the issue date, the only amount payable will be the premiums paid for the policy, less any debt against the policy.

Benefit amounts are subject to Gerber Life insurance limits.

A Buyer's Guide to Life Insurance and a Policy Summary are sent with all policies. You can get them without applying for insurance by writing to us.

Payment of benefits under the endowment policy is the obligation of, and is guaranteed by, Gerber Life Insurance Company. Guarantees are based on the claims paying ability of Gerber Life.

Gerber Life Insurance is a trademark. Used under license from Société des Produits Nestlé S.A. and Gerber Products Company.

Policy form series PIE-09-CA



**Gerber Life Insurance Company**

445 State Street, Fremont, Michigan 49412  
www.gerberlife.com

**Primary Agent Name:** \_\_\_\_\_ **Agent #:** \_\_\_\_\_

**Agency Name:** \_\_\_\_\_ **Applicant's Name:** \_\_\_\_\_

## **SECONDARY AGENT - AGENT SPLIT REQUEST**

Please review the following outline of requirements:

- ✓ This form must be sent in at time of application in order for a split commission to be applied.
- ✓ Split Commissions are allowed between two agents only.
- ✓ The name, agent ID, and split percentage for the secondary agent must be included in the request.
  - If the percentage of the split is missing, it will default to 50% for each agent for the life of the policy.

Please provide secondary agent information for split commissions:

**First Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Gerber Life Agent ID:** \_\_\_\_\_

*(If agent ID is not known, write in 9999-9999)*

**Percent of Split:** \_\_\_\_\_ %

## **SUPPLEMENT TO AN APPLICATION FOR INDIVIDUAL ENDOWMENT POLICY**

Gerber Life Insurance Company  
445 State Street  
Fremont, MI 49412

This form is a supplement to the application for an Individual Endowment policy on the following proposed insured:

First name:\_\_\_\_\_ Middle name:\_\_\_\_\_ Last name:\_\_\_\_\_

The owner of the Individual Endowment policy is to be:

First name:\_\_\_\_\_ Middle name:\_\_\_\_\_ Last name:\_\_\_\_\_

Address:\_\_\_\_\_ City:\_\_\_\_\_ State:\_\_\_\_\_ Zip:\_\_\_\_\_

Date of Birth:\_\_\_\_\_ Telephone number:\_\_\_\_\_ Social Security Number\_\_\_\_\_

Email:\_\_\_\_\_

What is the owner's relationship to the insured?\_\_\_\_\_

It is understood and agreed that:

All statements and answers made in all parts of the application are true and complete to the best of my knowledge and belief, and shall be the basis for and become part of any policy issued as a result of this application. Any policy issued shall not take effect until it is approved and the initial full premium(s) due have been received by the Company while the proposed insured is alive and all statements and answers in all parts of the application continue to be true and complete. I will notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is approved and payment is received by the Company.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Owner's Signature:\_\_\_\_\_ City/State: \_\_\_\_\_ Date:\_\_\_\_\_

AIESUPP-09

Name of Proposed Insured: \_\_\_\_\_

Application number: \_\_\_\_\_

**GERBER LIFE INSURANCE COMPANY****Authorization to Obtain, Use, and Disclose Personal Information  
(Insurance Eligibility)****PURPOSES**

This authorization applies to any Personal Information (defined below) that may be obtained, used, or disclosed about the Proposed Insured by the Gerber Life Insurance Company (the "Company," "we", or "us") for the purpose of determining the Proposed Insured's eligibility for insurance, which may include the processing of an application for insurance or any other legally permissible activities that relate to any coverage with the Company.

**PERSONAL INFORMATION**

I understand and agree that the types of "Personal Information" that may be obtained, used, or disclosed about the Proposed Insured on the basis of this authorization may include, to the extent permitted by law:

- (i) any and all health records about the Proposed Insured, including, but not limited to, information regarding medical, mental, or physical condition and treatment, prescription drug history, lab results, drug or alcohol use, and the diagnosis and treatment of Human Immunodeficiency Virus ("HIV") or other sexually transmitted diseases; and,
- (ii) non-health information about the Proposed Insured, including, but not limited to, information regarding finances, demographics (date of birth, birthplace, state of residence, etc.), employment, general reputation, insurance (including previous application activities), credit history, criminal history, and driving history.

Personal Information does not include psychotherapy notes unless such notes are included with the medical record.

**AUTHORIZATION FOR OTHERS TO DISCLOSE TO US**

I authorize all of the following classes of people or entities to disclose Personal Information about the Proposed Insured to the Company and its authorized agents and representatives: physicians, medical practitioners, hospitals, clinics, laboratories, pharmacies, pharmacy benefit managers, medical care facilities, and all other providers of medical services or sources of medical records; consumer reporting agencies; financial sources; business associates; past or current employers; benefit plan sponsors; government units, including the Department of Motor Vehicles; the Medical Information Bureau (MIB); and insurance companies. I further authorize the Company, and its authorized agents and representatives, to collect and process such Personal Information. **By signing below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of Personal Information about the Proposed Insured does not apply to this authorization.**

**AUTHORIZATION FOR US TO DISCLOSE TO OTHERS (AND POTENTIAL FOR RE-DISCLOSURE)**

I understand that the Company may disclose Personal Information for the purposes stated in this authorization to the Company's underwriters, administrators, reinsurers, contractors or others who may perform business services for the Company, or to the beneficiaries or other owners of the Proposed Insured's policy. In addition, Personal Information may be disclosed (i) to the Medical Information Bureau (MIB) in an effort to deter fraud, misrepresentation, or criminal activity, or (ii) as otherwise required or permitted by law. Personal Information which is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and may no longer be protected under federal or state privacy laws.

**FAILURE TO SIGN**

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the Company may not be able to issue the insurance for which I am applying or may not be able to make benefit payments.

**DURATION AND REVOCATION**

Unless revoked earlier, this authorization will remain in effect for 24 months\* from the date signed. I understand that I may revoke this authorization at any time, by written notice to:

Gerber Life Insurance Company  
ATTN: Underwriting Department  
445 State Street  
Fremont, MI 49412

I understand that my right to revoke this authorization is limited to the extent that the Company has already taken action in reliance upon this authorization or the law allows the Company to contest the issuance of a policy or a claim under a policy.

**COPIES OF THIS FORM**

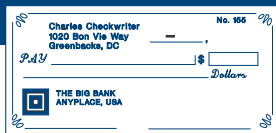
I agree that a copy of this authorization form (including faxes and electronic transmissions of this form) will be as valid as the original for purposes of obtaining or disclosing the required Personal Information about the Proposed Insured. I also understand that I am entitled to obtain a copy of this authorization form.

\_\_\_\_\_  
Date\_\_\_\_\_  
Signature of Proposed Insured or Authorized Representative\_\_\_\_\_  
Relationship to Proposed Insured

\*For residents in the state of Minnesota, unless revoked earlier, this authorization will remain in effect for 12 months from the date signed.

Gerber Life will not charge your account any money until 3 days after your application is approved.

### How to pay your premiums automatically through your CHECKING ACCOUNT:



1. Complete and sign the Authorization Form below.
2. Please provide the required financial information. Contact your financial institution for the correct account and routing numbers.
3. Your first premium will be withdrawn 3 days after your application is approved by Underwriting. Please be sure that your checking account is adequately funded. *Please Note: For the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.*
4. Premiums will continue to be automatically withdrawn each month unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on this Form.

### How to pay your premiums automatically through MASTERCARD or VISA:



1. Complete and sign the Credit Card Authorization Form below.
2. Your first premium will be charged 3 days after your application is approved by Underwriting. *Please Note: For the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.*
3. Premiums will continue to be charged monthly to the credit card you select, unless you indicate a different time period by selecting 3 months, 6 months or 12 months in the space provided on the Form.

Questions? Call our toll-free number: **1-800-428-4947** Monday-Friday, 8:30am to 6pm (EST)

### Use this Authorization Form for payment by automatic withdrawal from CHECKING ACCOUNT

☐ **Yes**, I hereby authorize the bank or financial institution named below to pay my insurance premiums as indicated below, by automatic withdrawal from my checking account. **I understand that my 1st premium will not be withdrawn until 3 days after my application is approved by Underwriting and for the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name of Financial Institution \_\_\_\_\_

Type of Account: ☐ Checking ☐ Savings Bank Transit # \_\_\_\_\_ Account # \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
(Accountholder's Signature)

Please automatically withdraw my premiums every (check ☒ one): ☐ month ☐ 3 months ☐ 6 months ☐ 12 months

### Use this Credit Card Authorization Form for payment by MASTERCARD or VISA

☐ **Yes**, please charge my premiums to my credit card account. **I understand that my 1st premium will not be charged until 3 days after my application is approved by Underwriting and for the 1st premium draft Gerber Life Insurance Company is unable to honor a specific draft date.** I also understand that I may cancel this authorization at any time by notifying Gerber Life Insurance Company.

Please check ☒ one: ☐ Mastercard – Must contain 16 numbers ☐ VISA – Must contain 13 or 16 numbers

Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

X \_\_\_\_\_ Date \_\_\_\_\_  
(Cardholder's Signature)

Please charge my premiums every (check ☒ one): ☐ month ☐ 3 months ☐ 6 months ☐ 12 months





**Gerber Life  
Insurance Company**

California Sales to Seniors

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**AGENTS - IF YOU PLAN TO MEET WITH A CALIFORNIA SENIOR IN THEIR  
HOME READ THE FOLLOWING COMMUNICATION CAREFULLY!**

California Insurance Law requires agents to provide a written notice to individuals age 65 or older before meeting with the senior in their home. This notice must be provided no less than 24 hours, and no more than 14 days, prior to the initial meeting. However, if the senior has an existing relationship with an insurance agent and requests a meeting in the senior's home the same day, the notice may be hand delivered to the senior prior to the meeting. For your convenience, Gerber Life has created a form for our agents to use when meeting with a California senior in their home to sell Gerber Life products.

**INSTRUCTIONS**

- ✓ Please use the attached California Sales to Seniors Notice Form [DISC-SCRA (1012)] if you plan to meet with a California Senior in their home. This form should be provided to the senior within the time period specified above.
- ✓ You must provide your contact information (name, address, license number and telephone number) exactly as it appears on your California Insurance License.
- ✓ A copy should be kept on file (Do Not send to Gerber Life).

**IMPORTANT REMINDER**

When contacting a California senior in person or by phone, before making any statement other than a greeting, or asking the senior any other questions, you must:

- ✓ State that the purpose of the visit or call is to talk about insurance, or to gather information for a follow up visit to sell insurance; and
- ✓ state the name and titles of all persons arriving for appointment; and
- ✓ provide name of the insurer; and
- ✓ present a business card or other written identification to the senior.





Gerber Life  
Insurance Company

## California Sales Disclosure to Seniors

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Agent Name: \_\_\_\_\_

License #: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following [indicate all that apply]:

- ☐ Life insurance, including annuities
- ☐ Other insurance products [specify]: \_\_\_\_\_

You have the right to have other persons present at the meeting, including family members, financial advisors or attorneys.

You have the right to end the meeting at any time.

You have the right to contact the Department of Insurance for information, or to file a complaint.

California Consumer Communication Bureau:  
800-927-4357      TDD: 800-482-4833

The following individuals will be coming to your home: [list all attendees and insurance license information, if applicable].

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

License #: \_\_\_\_\_

License #: \_\_\_\_\_