



JLExpress App Checklist

Make sure your case is a good fit for our JLExpress App process.

Please contact Pat Baker if you have questions.

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Case Checklist

- ✓ This case was **NOT** Quick Quoted for underwriting issues.
 - *If yes, please review with a team member.*
- ✓ This client does **NOT** have an e-mail account.
 - *If not, this case is not a good fit.*
- ✓ The owner and the proposed insured are **NOT** the same person.
 - *If not, this case is not a good fit.*
- ✓ The proposed insured is **NOT** 18 -75 years old.
 - *If not, this case is not a good fit.*

Carriers Available





Client Information

First Name:		Middle:		Last Name:	
DOB:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Driver's Lic. #:		SS#:	
Phone#:	E-mail:				
Address:		City:	State:	ZIP:	
Country of Birth:		State of Birth:	Years at Address:		
US Citizen: Yes <input type="checkbox"/> No <input type="checkbox"/>		Employer:		Occupation:	
Best Time to Contact Client: Morning <input type="checkbox"/> Evening <input type="checkbox"/> Afternoon <input type="checkbox"/>			Income:	Assets:	
Bankruptcy: Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, when and discharged?		Liabilities:	Net Worth:

Beneficiary Information

First Name:		Middle:		Last Name:	
SSN or Tax ID:	D.O.B.:	Relationship:	Amount%:	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	

Beneficiary Information (If Applicable)

First Name:		Middle:		Last Name:	
SSN or Tax ID:	D.O.B.:	Relationship:	Amount%:	Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	

Underwriting Questions

Height:	Weight:	Member of the Armed Forces? Yes <input type="checkbox"/> No <input type="checkbox"/> Past Member <input type="checkbox"/>			
Have you ever used tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>If Yes, Date last used and type of tobacco:</i>					
Do you have a history of alcohol or substance (drug) abuse?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had any DUIs or reckless driving in the past 10 years?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had more than two moving motor vehicle violations in the past 3 years?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Has either parent or sibling had a history or passed away of cardiovascular disease, diabetes, or cancer prior to age 60?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had a life, health or disability insurance policy rated or declined?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you currently or plan to scuba dive, skydive, mountain climbing, pilot or any extreme sports?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Has insurance been declined, postponed, and offered other than applied for in the last year?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you currently applying, or have you applied for life insurance within the last year?					Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you reside or travel or plan to travel outside the U.S or Canada?					Yes <input type="checkbox"/> No <input type="checkbox"/>
If age 50 or greater, do you have a primary care physician and evidence of routine physicals?					Yes <input type="checkbox"/> No <input type="checkbox"/>
<i>If "Yes" answer given, please provide details:</i>					

Exiting Policy Information

Do you have any existing life insurance or Annuities? Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you replacing your existing Life Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<u>Carrier Name</u>	<u>Face Amount</u>	<u>Replacement?</u>	<u>Yr. Issued</u>		
		Yes <input type="checkbox"/> No <input type="checkbox"/>			
		Yes <input type="checkbox"/> No <input type="checkbox"/>			

Ownership Information (If Different Than Proposed Insured)

First Name:		Middle:		Last Name:	
SSN or Tax ID:		Relationship:		D.O.B.:	

Proposed Policy Information

<input type="checkbox"/> AIG <input type="checkbox"/> Banner <input type="checkbox"/> Cincinnati <input type="checkbox"/> Lincoln <input type="checkbox"/> Pacific Life <input type="checkbox"/> Principal <input type="checkbox"/> Protective <input type="checkbox"/> Prudential <input type="checkbox"/> Omaha <input type="checkbox"/> SBLI <input type="checkbox"/> Securian							
Plan Name:		Premium:		Face Amount:		Class Quoted:	
Temporary Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		Save Age: Yes <input type="checkbox"/> No <input type="checkbox"/>		<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly			
State of Sale:		Any Pending Insurance? Yes <input type="checkbox"/> No <input type="checkbox"/>		Purpose of Insurance:			
<input type="checkbox"/> Waiver of Premium <input type="checkbox"/> Accidental Death Benefit <input type="checkbox"/> Accelerated Benefit Rider <input type="checkbox"/> Return of Premium <input type="checkbox"/> Child Rider							



Producer Information

First Name:	Middle:	Last:
SSN:	Email:	Phone:
Did you see the client during the sale? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you related to the proposed insured? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, How?	Are you delivering the policy face to face? Yes <input type="checkbox"/> No <input type="checkbox"/>
Knowledge of proposed insured: Self <input type="checkbox"/> Known well for _____years? Know Slightly <input type="checkbox"/> Met Very Recently <input type="checkbox"/> Other:		

Second Producer Information

First Name:	Last:	Commission Split %
SSN:	Email:	Phone:
Any Processing Details ?		