

## Critical Illness Cash - Sales Kit

Sale Kit Includes the following:

- Application
- Conditional Receipt
- State Required Sales Forms



PLEASE INDICATE:  NEW COVERAGE  CHANGE TO EXISTING COVERAGE  CONTINUATION OF COVERAGE

Person(s) Proposed for Coverage

|  |  |                      |   |   |  |
|--|--|----------------------|---|---|--|
| <b>Primary Insured (Please Print)</b>  | First Name   | MI                   | Last Name                                   | Suffix  |  |
|  | <input type="text"/>   |                      |   |   |  |
|  | Birthdate (MM/DD/YYYY)   | State of Birth       | Height (Ft-In)                              | Weight  | Social Security Number   |
|  | <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="text"/> | <input type="text"/> - <input type="text"/> | <input type="text"/>  | <input type="text"/> - <input type="text"/> - <input type="text"/> |
|  | Address (Street or R.R.)   |                      |   |   | Gender   |
|  | <input type="text"/>   |                      |   |   | <input type="radio"/> Male <input type="radio"/> Female            |
|  | City   | State                | ZIP Code                                    | Home Telephone  |  |
| <input type="text"/>   |  |                      |   | <input type="text"/> ( <input type="text"/> ) <input type="text"/> - <input type="text"/> |  |
| Have you used any form of tobacco in the past 12 months?..... <input type="radio"/> Yes <input type="radio"/> No |  |                      |   |   |  |

|  |  |   |                      |  |   |                      |
|--|--|---|----------------------|--|---|----------------------|
| <b>Spouse</b>  | Spouse Name (First Name, MI, Last Name) (If proposed for coverage) |   |                      |  | Suffix  | State of Birth       |
|  | <input type="text"/>   |   |                      |  | <input type="text"/>                                    | <input type="text"/> |
|  | Birthdate (MM/DD/YYYY)   | Height (Ft-In)                              | Weight               | Social Security Number   | Gender  |                      |
|  | <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="text"/> - <input type="text"/> | <input type="text"/> | <input type="text"/> - <input type="text"/> - <input type="text"/> | <input type="radio"/> Male <input type="radio"/> Female |                      |
| Have you used any form of tobacco in the past 12 months?..... <input type="radio"/> Yes <input type="radio"/> No |  |   |                      |  |   |                      |

|                  |  |   |                      |  |   |                      |
|------------------|--|---|----------------------|--|---|----------------------|
| <b>Child One</b> | Child Name (First Name, MI, Last Name) (If proposed for coverage)  |   |                      |  | Suffix  | State of Birth       |
|                  | <input type="text"/>   |   |                      |  | <input type="text"/>                                    | <input type="text"/> |
|                  | Birthdate (MM/DD/YYYY)   | Height (Ft-In)                              | Weight               | Social Security Number   | Gender  |                      |
|                  | <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="text"/> - <input type="text"/> | <input type="text"/> | <input type="text"/> - <input type="text"/> - <input type="text"/> | <input type="radio"/> Male <input type="radio"/> Female |                      |

|                  |  |   |                      |  |   |                      |
|------------------|--|---|----------------------|--|---|----------------------|
| <b>Child Two</b> | Child Name (First Name, MI, Last Name) (If proposed for coverage)  |   |                      |  | Suffix  | State of Birth       |
|                  | <input type="text"/>   |   |                      |  | <input type="text"/>                                    | <input type="text"/> |
|                  | Birthdate (MM/DD/YYYY)   | Height (Ft-In)                              | Weight               | Social Security Number   | Gender  |                      |
|                  | <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="text"/> - <input type="text"/> | <input type="text"/> | <input type="text"/> - <input type="text"/> - <input type="text"/> | <input type="radio"/> Male <input type="radio"/> Female |                      |

|                    |  |   |                      |  |   |                      |
|--------------------|--|---|----------------------|--|---|----------------------|
| <b>Child Three</b> | Child Name (First Name, MI, Last Name) (If proposed for coverage)  |   |                      |  | Suffix  | State of Birth       |
|                    | <input type="text"/>   |   |                      |  | <input type="text"/>                                    | <input type="text"/> |
|                    | Birthdate (MM/DD/YYYY)   | Height (Ft-In)                              | Weight               | Social Security Number   | Gender  |                      |
|                    | <input type="text"/> / <input type="text"/> / <input type="text"/> | <input type="text"/> - <input type="text"/> | <input type="text"/> | <input type="text"/> - <input type="text"/> - <input type="text"/> | <input type="radio"/> Male <input type="radio"/> Female |                      |

**BENEFIT SECTION**

**Plan Type**  Individual (Adult)  Couple [(Individual and spouse/partner)]  
 Family (2 parents and all children)  Single Parent (Parent and all children)

**Base Plan (Select Only One)**  Vascular, Cancer and Other Illnesses  Vascular and Other Illnesses  Cancer Only

Primary Insured/Spouse Benefit Amount      Child(ren) Benefit Amount      Total Modal Premium  
 \$ [ ][ ][ ] , [ ][ ][ ]      \$ [ ][ ][ ] , [ ][ ][ ]      \$ [ ][ ][ ] . [ ][ ][ ]

**Optional Benefit:** Return of Premium  Yes  No

**Payment Method**  Bank Draft  Credit Card  Direct Bill/Check (Annual Billing Only)  
 [(Complete Bank Draft or Credit Card Authorization.)]

**Payment Mode**  Monthly  Semi-annual  Annual

Beneficiary:

- 100% to my Spouse, as recorded on Page 1 of this Application
- Other (List name, relationship and percentage share) \_\_\_\_\_

**APPLICANT'S REPRESENTATION AND AGREEMENT**

|  | Primary Insured                             | Spouse                                      | Child 1                                     | Child 2                                     | Child 3                                     |
|--|---|---|---|---|---|
|  | Yes/No                                      | Yes/No                                      | Yes/No                                      | Yes/No                                      | Yes/No                                      |
| 1. In the last 12 months, has any Person Proposed for Coverage:  |   |   |   |   |   |
| a. Been unable to perform their normal duties at work, home or school on a full-time basis due to an illness or disability?.....   | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| b. Missed more than 5 consecutive days of work or school due to an illness or injury?.....   | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 2. Has any Person Proposed for Coverage ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or tested positive for the antigens or antibodies to an AIDS or Human Immunodeficiency (HIV) virus?.....  | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 3. In the 6 months prior to the Application date, has any Person Proposed for Coverage been hospitalized as an inpatient or treated on an outpatient basis, except for minor injuries or normal pregnancy?.....  | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 4. Has any Person Proposed for Coverage ever been diagnosed with or treated for drug abuse or alcohol abuse, disease of the liver, kidney or digestive system, disease or disorder of the lung, diseases of the nervous system, including Parkinson's, multiple sclerosis, cerebral palsy, hemiplegia, paraplegia, quadriplegia, or any disease or disorder which has led or may lead to a permanent or progressive loss of vision or speech?..... | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 5. Has any Person Proposed for Coverage ever been diagnosed with or treated for heart disease, including angina, heart attack, congestive heart failure, heart bypass, cerebrovascular disease including Transient Ischemic Attack (TIA), stroke (blockages or hemorrhage), diabetes, or blood pressure readings above the normal range which have not been controlled with medication?.....   | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 6. Has any Person Proposed for Coverage ever been diagnosed with or treated for Cancer, including melanoma, leukemia, lymphoma, malignant tumors, or skin cancers?.....  | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| 7. To the best of your knowledge and belief, have any two of your natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list:  |   |   |   |   |   |
| a. Vascular: heart attack, heart disease or stroke?.....   | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| b. Cancer: cancer?.....  | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |
| c. Other: kidney disease, diabetes?.....   | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> | <input type="radio"/> <input type="radio"/> |





**FOR INSURANCE PRODUCER'S USE ONLY**

I certify that I have truly and accurately recorded on the application the information supplied by the Person(s) Proposed for coverage. I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Will this insurance replace any existing insurance?.....  Yes  No

Date (MM/DD/YYYY)

|  |  |   |  |  |   |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|
|  |  | / |  |  | / |  |  |  |  |
|--|--|---|--|--|---|--|--|--|--|

Signature of Licensed Insurance Producer \_\_\_\_\_

Printed Name of Licensed Insurance Producer \_\_\_\_\_

| Insurance Producer Number | % Credit | Insurance Producer Number | % Credit | Insurance Producer Number | % Credit |
|---------------------------|----------|---------------------------|----------|---------------------------|----------|
|                           |          |                           |          |                           |          |
|                           |          |                           |          |                           |          |
|                           |          |                           |          |                           |          |

**MIB Disclosure Notice** - Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. Kanawha Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, email address [www.mib.com](http://www.mib.com) and telephone number (781) 751-6000. Kanawha Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE TO PROPOSED INSURED

Thank you for giving Kanawha the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. This includes your prescription drug history and information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. We may telephone you to confirm information given in your Application or to obtain additional information needed to process your Application. All information asked for in your Application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

# KANAWHA INSURANCE COMPANY

[210 S. WHITE STREET]  
[LANCASTER, SC 29720]

[PO BOX 610]  
[LANCASTER, SC 29721-0610]

TELEPHONE: [877-207-0158]

## OUTLINE OF COVERAGE FOR [CANCER][AND][SPECIFIED DISEASE] POLICY FORM 70620 NC

### A LIMITED BENEFITS POLICY

**PLEASE READ YOUR POLICY CAREFULLY.** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract. Only the actual Policy terms will control. The Policy itself states the rights and duties of both You and Kanawha Insurance Company ("Kanawha"). The Policy also states the benefits and requirements. It is therefore important that **YOU READ YOUR POLICY CAREFULLY!** Please contact Us if You have questions.

**LIMITED BENEFITS COVERAGE.** Policies of this type are designed to provide covered persons with limited or supplemental coverage. The Benefits Summary section below outlines the coverage provided by the Policy. Benefits described in the Benefits Summary may be limited by the Conditions and Limitations, Waiting Period and Exclusions sections, and other terms in Your Policy.

**NO RECOVERY FOR PRE-EXISTING CONDITIONS.** No benefits will be provided during the first 12 months of the Policy and any attached Rider for any Pre-existing Condition. The term Pre-existing Condition is:

- defined in the Policy; and
- may be added to or changed in a Policy Rider.

#### POLICY BENEFITS SUMMARY

**Critical Illness Lump Sum Benefit.** We will pay a lump sum percentage of the Face Amount to the Policy Owner when a Covered Person suffers from a covered Critical Illness.

Coverage shown is only effective if approved by Us. If coverage is approved by Us, it will be made effective at 12:01 a.m. local time in the Covered Person's state of residence on the date We approved it.

#### Face Amounts are: (Check persons applied for.)

- For Primary Insured [\$#,###.##]
- For Spouse [If applied for, same a Primary Insured]
- For Children [\$#,###.##]

The Face Amount reduces by 50% when a Covered Person reaches Age 70.

A set of Critical Illnesses is called a Benefit Group. Based on Your application to Us and Our approval, Your Policy will cover the [Vascular][,] [and] [Cancer][and] [Other Critical Illnesses] Benefit Group[s]. [This][These] Benefit Group[s] [is][are] summarized below.



Benefits shown are only effective if approved by Us.

**Benefit Groups**  
**(Check those applied for.)**

- [Vascular:
- |                                |                       |
|--------------------------------|-----------------------|
| Heart Attack                   | [100%] of Face Amount |
| Heart Transplant               | [100%] of Face Amount |
| Stroke                         | [100%] of Face Amount |
| Coronary Artery Bypass Surgery | [25%] of Face Amount] |
- [Cancer:
- |                                       |                       |
|---------------------------------------|-----------------------|
| Invasive Cancer or Malignant Melanoma | [100%] of Face Amount |
| Carcinoma in Situ                     | [25%] of Face Amount] |
- [Other Critical Illnesses:
- |  |                        |
|--|------------------------|
| Major Organ Transplant                       | [100%] of Face Amount  |
| End Stage Renal Failure                      | [100%] of Face Amount  |
| Loss of Speech or Vision                     | [100%] of Face Amount  |
| Coma   | [100%] of Face Amount] |
| Permanent Paralysis due to Accidental Injury | [100%] of Face Amount] |

Each Critical Illness is defined in the Policy.

For each Covered Person during the entire time that the Policy is in force:

- payment of Benefits within a Benefit Group will not exceed [100%] of the Face Amount[;].]
- payment of Benefits within the [Vascular] [and] [Cancer] Benefit Group[s] will not exceed [100%] of the Face Amount[.];][and]
- payment of Benefits within the Other Critical Illnesses Benefit Group will not exceed [50%] of the Face Amount.]

**GUARANTEED RENEWABLE.** You can keep the Policy during the Primary Insured's lifetime. You must pay each Premium due before the end of the Grace Period. Your Premium can be changed, if We change the Premium on all policies in Your Policy's Premium class. Premiums may also vary based on Your state of residence.

Insurance on a Covered Person ends when We have paid 100% of the Face Amount in each Benefit Group covering that person.

**PREMIUM.** Your first Premium is [\$###.##]. Your renewal Premium is stated below. Your Premium is subject to change as outlined above and as stated in Your Policy.

Payment  
Mode:       Monthly Direct     Monthly Bank Draft     Quarterly     Semi-Annual     Annual  
Modal  
Premium:    \$[\_\_\_\_\_]

[Notice: A collection fee of [\$12.00] annually will be applied to all policies billed by credit card. This fee may be changed annually.]

If You have Rider coverage under Your Policy, it is included in the above stated Premium.

**GRACE PERIOD.** A Grace Period of 31 days is provided for payment of each Premium due, except for the first Premium. Coverage will remain in force during the Grace Period.

## **BENEFIT CONDITIONS AND LIMITATIONS**

The following will apply to the policy. For each Covered Person —

Any loss due to a Pre-existing Condition will not be covered if the loss begins within 12 months after his or her Effective Date.

When a named Critical Illness is contributed to or caused by another named Critical Illness, We will pay only one Benefit. The Benefit paid will be the larger. If the Benefits are equal, the Policy Owner may choose the Benefit to be paid.

A Critical Illness that occurs during the 30-day period after his or her Effective Date is not covered.

[A Clinical or Pathological Diagnosis of Invasive Cancer during the 30-day period after his or her Effective Date is not covered.]

[Benefits for Invasive Cancer or Carcinoma in Situ will not be payable based on a Tentative Diagnosis.]

[All Vascular Benefits end when We have paid [100%] of his or her Face Amount for any of the following:

- Heart Attack;
- Heart Transplant; [or]
- Stroke.]

[When We pay a Benefit for Coronary Artery Bypass Surgery, his or her Face Amount for other Vascular Benefits is reduced by [25%.]

[All Cancer Benefits end when We have paid [100%] of his or her Face Amount for Invasive Cancer.]

[When We pay a Benefit for Carcinoma in Situ, his or her Face Amount for Invasive Cancer is reduced by [25%.]

[All Other Critical Illness Benefits end when We have paid [100%] of his or her Face Amount for any of the following:

- Major Organ Transplant;
- End Stage Renal Disease;
- Loss of Vision or Speech;
- Coma; or
- Permanent Paralysis.]

## **WAITING PERIOD**

A loss otherwise insured by the Policy is not covered if it occurs within 30 days after a Covered Person's Effective Date.

## EXCLUSIONS

The following will apply to the policy.

No Benefits of the Policy or Riders attached to it will be paid for loss that is contributed to, caused by, or occurs during:

- any intentionally self-inflicted Injury;
- suicide, or attempted suicide, while sane or insane;
- active duty military service;
- participation in the commission or attempted commission of a felony;
- being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless administered on, and taken in accordance with, the instructions of a Doctor;
- psychosis; or
- alcoholism or drug addiction.

**OPTIONAL RETURN OF PREMIUM BENEFIT RIDER (FORM 70622) (Check if applied for.)**

### Return of Premium Benefit

We will return all Premiums paid on the Policy and Riders attached to it on the 20<sup>th</sup> anniversary of the Date of Policy if:

- Premiums of the Policy are paid to the 20<sup>th</sup> anniversary of the Date of Policy;
- this Rider is then in force; and
- **no claim for** a Critical Illness Benefit has been paid or incurred.

On the second and any later 20-Year Anniversary, We will return all Premiums paid on the Policy and Riders attached to it since the prior 20-Year anniversary if:

- Premiums of the Policy are paid to the then current 20-Year Anniversary;
- this Rider is then in force; and
- no claim for a Critical Illness Benefit has been paid or incurred.

We will pay any Return of Premium Benefit to You.

After a Return of Premium Benefit is paid, You can keep the Policy, this Rider and any other Riders by paying the Premiums for them.

### Rider Limitations

If any Critical Illness Benefit is paid for a Covered Person of the Policy, this Rider ends.

If this Rider ends, no Return of Premium Benefit will be payable on any 20-Year Anniversary that takes place after this Rider ends.]

**RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70620 NC**

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**Signature of Applicant**

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**Date**

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**Signature of Licensed Resident Agent**

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**Date**

**THIS PORTION RETAINED BY APPLICANT**

1678 NC

**RECEIPT FOR OUTLINE OF COVERAGE FOR POLICY FORM 70620 NC**

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**Signature of Applicant**

---

**Date**

---

**Signature of Licensed Resident Agent**

---

**Date**

**THIS PORTION RETAINED BY KANAWHA INSURANCE COMPANY**

1678 NC

## **KANAWHA INSURANCE COMPANY**

Mail: Post Office Box 610, Lancaster, South Carolina 29721-0610  
Delivery: 301 South Main Street, Lancaster, South Carolina 29720  
1-800-378-1505 (toll free) or 803-283-5300

|  |
|--|
| <p><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE</b><br/><b>THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS.</b></p> |
|--|

### **This is not Medicare Supplement insurance.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance, and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- Hospitalization
- Physician services
- Hospice
- Other approved items and services

|   |
|---|
| <p><b>BEFORE YOU BUY THIS INSURANCE</b></p> |
|---|

- ✓ Check the coverage in all health policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare* available from Kanawha Insurance Company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Proposed Insured

## CONDITIONAL RECEIPT

*A Conditional Receipt is to be given to an applicant upon receipt of the applicant's check as a deposit for the modal premium(s) for the Policy(ies) applied for herein.*

**Make checks payable to Kanawha Insurance Company. Do not make payable to Insurance Producer or leave payee blank.**

Received from \_\_\_\_\_ the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Name Month Year

the sum of \$ \_\_\_\_\_ being the payment of \_\_\_\_\_ month(s) premium for the following policies

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The insurance applied for shall not take effect until:

- the date of Policy,
- payment of the modal premium, and
- the Proposed Insured(s) has been approved for coverage as applied.

In the event the application is declined, any payment made by the applicant will be returned.

**No coverage is provided under this Conditional Receipt unless the conditions on this receipt are fulfilled.**

**No coverage is provided for any claims that begin prior to the approval date.**

**No coverage is provided under this Conditional Receipt if the Proposed insured misrepresented a material fact or facts in the Application for insurance/ reinstatement Application.**

**No insurance producer can waive or alter any of the conditions or requirements stated on this conditional receipt.**

\_\_\_\_\_  
Signature of Insurance Producer/Policy Administrator

\_\_\_\_\_  
Telephone Number of Insurance Producer