

POLICY INFORMATION

<input type="text"/> Owner Name	<input type="text"/> Owner Phone	<input type="checkbox"/> Yes <input type="checkbox"/> No GWG Permission to call?
<input type="text"/> Owner Address		
<input type="text"/> Policy Number	<input type="text"/> Carrier	
<input type="text"/> Issue Date	<input type="text"/> Face Value	
<input type="text"/> Reason for Xchange (Choose one)	<input type="text"/> Solution Preference (Choose one)	
<input type="text"/> Comments		

INSURED(S) INFORMATION

<input type="text"/> 1st Insured Name	<input type="text"/> 2nd Insured Name (if applicable)
<input type="text"/> Date of Birth	<input type="text"/> Date of Birth
<input type="checkbox"/> M <input type="checkbox"/> F Gender	<input type="checkbox"/> M <input type="checkbox"/> F Gender
<input type="text"/> Phone	<input type="text"/> Phone
<input type="checkbox"/> Yes <input type="checkbox"/> No GWG Permission to call?	<input type="checkbox"/> Yes <input type="checkbox"/> No GWG Permission to call?
<input type="text"/> State of Residence	<input type="text"/> State of Residence
<input type="text"/> List of Health Conditions	<input type="text"/> List of Health Conditions

FOR INTERNAL USE

<input type="text"/> BGA/BD Affiliation
<input type="text"/> Company
<input type="text"/> Referring Agent/Advisor
<input type="text"/> GWG Contact

When complete, email this document to your GWG Life Contact or agents@gwglife.com
Attach your digital book of business (if applicable).

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