



## TRANSMITTAL REPORT

Team:  Gold Phone: 800 669-9100 Fax: 800 951-9430

**PLEASE PRINT**

Agency Name		Producer Code		Contact Person/E-mail Address	
Address				Fax Number	
City	State	Zip Code	Phone No.		
Writing Agent	Phone No.		Agent Code		

Proposed Insured (1)		
Proposed Insured (2)		
Plan of Insurance	Face Amount (1)	Face Amount (2)
PREMIUM SUBMITTED \$ _____ Please attach a copy of Illustration		

Please indicate by placing an O if ordered or A if attached next to the requirement.

Proposed Insured (1)	Requirement	Proposed Insured (2)
_____	Paramedical Exam	_____
_____	Date ordered _____	_____
_____	Physical Measurements/Vitals	_____
_____	MD Exam	_____
_____	EKG	_____
_____	Treadmill	_____
_____	APS Dr. _____	_____
_____	Date ordered _____	_____
_____	Vendor Name _____	_____
_____	APS Dr. _____	_____
_____	Date ordered _____	_____
_____	Vendor Name _____	_____
_____	Confidential Financial Statement	_____
_____	Urine/HIV	_____
_____	Full Blood Profile	_____
_____	Replacement Forms	_____
_____	Illustration	_____
_____	Cover Letter	_____
_____	Underwriter Checklist	_____
_____	Other (describe) _____	_____

**Please complete the following:**

**BCX**

TeleMed Interview. (The best day, time and number to call must be indicated on Part I of the application).

No TeleMed Interview (Exam Questions Completed by Examiner, Application Parts I & II, Questions 1-22, completed by Agent)

**POLICY NUMBER:** \_\_\_\_\_  
(if applicable)

**HAS THIS APPLICATION BEEN FAXED ?**  YES  NO

**If "No" please ship to:**

**New Business Department  
North American Company  
One Midland Plaza  
Sioux Falls, SD 57117**

**Special Requests/Remarks** (i.e. Policy Date, Trust Date, 1035 Information etc. Include cover letter for financial justification or special circumstances)

Date submitted: \_\_\_\_\_

By: \_\_\_\_\_