

# Cincinnati Life Drop Ticket

**DISCLAIMER: Only available for face amounts \$100,000 or greater.**

## Insured Information

Estimated Rate Class: \_\_\_\_\_ Product: \_\_\_\_\_  
Face Amount \_\_\_\_\_ State \_\_\_\_\_ DOB \_\_\_\_\_  
Client Name: \_\_\_\_\_ Tobacco Y/N \_\_\_\_\_  
SSN \_\_\_\_\_ State/Country of Birth \_\_\_\_\_ U S Citizen? \_\_\_\_\_  
Full Address: \_\_\_\_\_  
Best Contact Number: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_  
Payment Mode: \_\_\_\_\_ Direct Bill or EFT? \_\_\_\_\_  
Need for coverage: Income replacement \_\_\_ Debt \_\_\_ Estate conservation \_\_\_  
State of solicitation \_\_\_\_\_ Riders? \_\_\_\_\_ Is coverage business or personal? \_\_\_\_\_  
Gross annual salary \_\_\_\_\_ Total liabilities \_\_\_\_\_ Total Assets \_\_\_\_\_  
Email Address: \_\_\_\_\_

## Owner Information (Only Complete when Insured is NOT the Owner)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_  
Will the payor be someone other than the insured? \_\_\_\_\_

## Beneficiary Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address (If different from Insured): \_\_\_\_\_  
Any contingent beneficiaries? \_\_\_\_\_ Type-Individual, trust or other? \_\_\_\_\_

## Existing Policies (Please Include all Inforce Policies):

Name of Insurer: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Product: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Product: \_\_\_\_\_  
Name of Insurer: \_\_\_\_\_ Face Amount: \_\_\_\_\_ Product: \_\_\_\_\_  
Are any to be Replaced? \_\_\_\_\_ Reason for Replacement? \_\_\_\_\_