

**BBG/CPS**  
**Brown, Brown & Gomberg/CPS**

**VERIFICATION OF COVERAGE FORM**

Policy Number: \_\_\_\_\_

1<sup>st</sup> Insured: \_\_\_\_\_

2<sup>nd</sup> Insured: \_\_\_\_\_

**PLEASE PROVIDE THE FOLLOWING INFORMATION AS ISSUER OF THE ABOVE-REFERENCED LIFE INSURANCE POLICY:**

(1) PLEASE PROVIDE THE NAME OF THE CURRENT POLICY OWNER:

\_\_\_\_\_

(2) PLEASE LIST THE NAME(S) OF THE BENEFICIARY(IES) (If any Beneficiary is an Irrevocable Beneficiary, please so indicate)

1<sup>st</sup> Primary \_\_\_\_\_  Irrevocable Beneficiary

2<sup>nd</sup> Primary \_\_\_\_\_  Irrevocable Beneficiary

3<sup>rd</sup> Primary \_\_\_\_\_  Irrevocable Beneficiary

(3) PLEASE PROVIDE THE MATURITY DATE OR THE OLDEST AGE OF THE INSURED(S) AT WHICH THE FULL DEATH BENEFIT OF THE POLICY IS PAYABLE

\_\_\_\_\_

(4) POLICY TYPE:

Term Life

Whole Life

Universal Life

Variable Whole Life

Variable Universal Life

Survivorship Whole Life

Survivorship Universal Life

OTHER (Please Specify)

\_\_\_\_\_

(5) FACE AMOUNT OF THIS POLICY

\$ \_\_\_\_\_

(6) CURRENT NET DEATH BENEFIT OF THIS POLICY

\$ \_\_\_\_\_

(7) ARE THERE ANY LIENS OR COLLATERAL ASSIGNMENTS OUTSTANDING AGAINST THIS POLICY?

YES

NO

IF YES, PLEASE SPECIFY THE TOTAL AMOUNT ASSIGNED OR OUTSTANDING:

\$ \_\_\_\_\_

as of (Date) \_\_\_\_\_

(8) ARE ANY LOANS OR ACCRUED INTEREST OUTSTANDING ON THIS POLICY?

YES

NO

IF YES, PLEASE SPECIFY THE TOTAL AMOUNT OUTSTANDING:

\$ \_\_\_\_\_

as of (Date) \_\_\_\_\_

(9) WHAT IS THE DEATH BENEFIT OPTION CURRENTLY APPLICABLE TO THIS POLICY? (Applies to Universal Life Policies)

Option 1 (Level Death Benefit)

Option 2 (Cash Value Added to Death Benefit)

(10) WHAT IS THE CURRENT CASH SURRENDER VALUE OF THIS POLICY?

\$ \_\_\_\_\_

as of (Date) \_\_\_\_\_

(11) WHAT IS THE CURRENT ACCUMULATION OR ACCOUNT VALUE OF THIS POLICY?

\$ \_\_\_\_\_

as of (Date) \_\_\_\_\_

(12) WHAT IS THE EFFECTIVE ISSUE DATE OF THIS POLICY?

\_\_\_\_\_

(13) IS THIS POLICY CURRENTLY CONTESTABLE?

YES

NO

(14) IS THIS POLICY CURRENTLY SUBJECT TO A SUICIDE EXCLUSION PERIOD?

YES

NO

(15) HAS THIS POLICY EVER LAPSED?

YES

NO

IF YES, PLEASE PROVIDE THE DATE OF REINSTATEMENT

\_\_\_\_\_

IS THE REINSTATED POLICY CONTESTABLE?

YES

NO

(16) IS THIS POLICY ASSIGNABLE AND/OR TRANSFERABLE?

YES  NO

(17) WHAT IS THIS POLICY'S CURRENT PREMIUM MODE?

Monthly  Quarterly  
 Semi-Annual  Annual

(18) WHAT IS THE MODAL PREMIUM FOR THIS POLICY?

\$ \_\_\_\_\_

(19) WHAT IS THE CURRENT PREMIUM DUE ON THIS POLICY (If Any)?

\$ \_\_\_\_\_

a. Is this premium a "Minimum Required Premium" such that if this premium is PAID as defined in the policy, the policy will not lapse EVEN IF THE CASH SURRENDER VALUE OF THE POLICY IS NEGATIVE?

YES  NO

b. Is this premium a "Minimum Required Premium" such that if this premium is NOT PAID but the policy's cash surrender value remains positive, the policy will not lapse unless and until either the policy's cash surrender value is \$0.00 or at the policy's Maturity Date whichever occurs first?

YES  NO

c. Is this premium a "Minimum Required Premium" such that if this premium is NOT PAID the policy will lapse EVEN IF THE POLICY'S CASH SURRENDER VALUE IS POSITIVE?

YES  NO

(20) ON WHAT DATE IS THE NEXT PREMIUM DUE ON THIS POLICY?

\_\_\_\_\_

(21) DOES THIS POLICY HAVE A WAIVER OF PREMIUM OR WAIVER OF COST OF INSURANCE BENEFIT?

YES  NO

(22) DOES THIS POLICY HAVE AN ACCELERATED BENEFITS RIDER OR PROVISION?

YES  NO

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

WHAT IS THE MAXIMUM AMOUNT OF DEATH BENEFIT THAT CAN BE ACCELERATED?

\$ \_\_\_\_\_

WHAT IS THE MINIMUM AMOUNT OF DEATH BENEFIT THAT CAN BE ACCELERATED?

\$ \_\_\_\_\_

HAS THE ACCELERATED DEATH BENEFIT RIDER/PROVISION FOR THIS POLICY BEEN UTILIZED?  
 YES  NO

**PLEASE PROVIDE THE FOLLOWING INFORMATION WITH REGARD TO WHERE CHANGE OF OWNERSHIP, ABSOLUTE ASSIGNMENT AND CHANGE OF BENEFICIARY FORMS SHOULD BE SENT:**

CONTACT PERSON: \_\_\_\_\_  
TITLE: \_\_\_\_\_  
COMPANY: \_\_\_\_\_  
DEPARTMENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
CITY: \_\_\_\_\_  
STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_ EXT.: \_\_\_\_\_  
FAX: \_\_\_\_\_  
E-MAIL: \_\_\_\_\_

**WILL FACSIMILE COPIES OF EXECUTED CHANGE FORMS BE ACCEPTED AND PROCESSED?**  
 YES  NO

NAME: \_\_\_\_\_  
(PLEASE PRINT)  
TITLE/DEPT.: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_  
DIRECT EXTENSION: \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_  
(PLEASE SIGN)  
FOR: \_\_\_\_\_  
(PRINT NAME OF INSURANCE COMPANY)  
DATE: \_\_\_\_\_