

INSURANCE DESK

New Business Transmittal

Date:

Please submit with **ALL NEW** applications.

Mail to: Insurance Desk/IMS · 168 Centre Street, Danvers, MA 01923

Carrier Name:

Applicant Name:

SSN:

Contact Information:

1st Writing Agent:

%

Carrier Agent #

2nd Writing Agent:

%

Carrier Agent #

Mailing Address:

Phone:

Fax:

Email Address:

Preferred method of contact:

Fax

Email

Appointment Information:

Is agent appointed with carrier? Yes No

If No, are carrier appointment forms attached? Yes No - If No, date submitted to carrier:

Requirement Information:

Were medical requirements ordered? Yes No

Company:

Was APS ordered? Yes No

Name of Doctor:

Enclosures:

Application

Paramed

Lab Slip

Consent Form

Replacement Forms

Disclosure Statement

Premium (Check # Amount \$) **Attach conditional receipt**

Illustration

APS

Other

Other