

Insurance Company Name:

Date:

Agent:

Agent Code:

Agency: Complete Brokerage Service Inc.

**APPLICATION TRANSMITTAL**

<b>1st Insured:</b>	<b>Coverage \$</b>	<b>FYC \$</b>
<b>2nd Insured:</b>	<b>Coverage \$</b>	Joint / Multi Life
<b>Plan:</b> <input type="checkbox"/> Term <input type="checkbox"/> UL <input type="checkbox"/> WL <input type="checkbox"/> CI <input type="checkbox"/> DI <input type="checkbox"/> Investment		
<input type="checkbox"/> New application <input type="checkbox"/> Additional applicaiton <input type="checkbox"/> Alternate application		
Other instructions:		

**Enclosures**

- |  |  |
|--|--|
| <input type="checkbox"/> Cheque \$ _____               | <input type="checkbox"/> <b>Illustration (must included)</b> |
| <input type="checkbox"/> Void cheque                   | <input type="checkbox"/> BC disclosure form                  |
| <input type="checkbox"/> Cover or Consent Letter       | <input type="checkbox"/> Replacement Form                    |
| <input type="checkbox"/> Supplementary or Product page | <input type="checkbox"/> _____                               |

**Requirements ALREADY ordered by Associate - COMPANY NAME \_\_\_\_\_**

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Non-medical | <input type="checkbox"/> Paramed             |
| <input type="checkbox"/> Urine       | <input type="checkbox"/> Dr's Medical Report |
| <input type="checkbox"/> Blood       | <input type="checkbox"/> Inspection Report   |
| <input type="checkbox"/> Vital       | <input type="checkbox"/> ECG/EKG             |
| <input type="checkbox"/> Saliva      | <input type="checkbox"/> _____               |

**Requirements to be ordered by Case Coordinator**

- |  |   |
|--|---|
| <input type="checkbox"/> Inspection Report   | <input type="checkbox"/> Stress ECG/EKG |
| <input type="checkbox"/> Dr's Medical Report | <input type="checkbox"/> X-Ray          |
| <input type="checkbox"/> Blood Profile       | <input type="checkbox"/> MVR            |
| <input type="checkbox"/> ECG/EKG             | <input type="checkbox"/> APS            |
| <input type="checkbox"/> _____               | <input type="checkbox"/> _____          |

**Contact**

Email:	
Hub Case Coordinator: (604) 684-0086	
Office: (    )	Cellular: (    )
Fax: (    )	
Assistant:	