

Important Notice to << Full name >> Complete and Return

Lender:

<<Lender Name >>

To Borrower:

<<Full Name>>
<<Address 2>>
<<Address 1>>
<<City, ST Zip>>

<<Barcode>>

Registration#:<<Reg. number>>

Tracking#: <<Track number>>

Co-Borrower: <<First Name>>

Dear <<Name Field>>,

You are entitled to participate in an affordable Mortgage Protection Program which can protect your \$<<Mortgage Amount>> loan in case of an unexpected Death or Disability. Your family would still have to make your monthly mortgage payments without this type of plan,

<<Name Field>>, **your benefits can include:**

- **Death** - Pays off your <Mortgage Amount> loan in the event if your death from Accidental or Natural Causes
- **Disability** - Pays off your Mortgage Loan payments if you become sick or injured & cannot work
- **Return of premiums** - Returns all premiums if the benefits are not used by the end of the protection term
- **Knowing <<Name Field>>'s family will not lose their home.**

For complete details at no cost or obligation

Please complete and return this form in the enclosed postage paid envelope

<<Name field>> <<Address>> <<City, ST Zip>>		Loan Amount:
Lender: <<Lender name >>		\$<<Mortgage Amount>>
EPIS073008-01		
Date of Birth:	<i>Borrower</i> ____/____/____	<i>Spouse/ Co-Borrower</i> ____/____/____
Gender:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>
Height:	____ft ____in	____ft ____in
Weight:	____lbs.	____lbs.
Have you ever had:		
1. High blood pressure/High Cholesterol?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Heart Attack, Stroke or Cancer?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Used tobacco in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Occupation: _____		
Home # (_____) _____ - _____ Work # (_____) _____ - _____		
Cellular # (_____) _____ - _____ Best time to call: _____AM/PM		
Name of person completing this form: _____		

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