A. Personal Information

1. First Name _____ MI _____ Last Name _____

2. Birth Date _____ Birth State/Country _____ Gender ☐ Male ☐ Female

3. E-mail _____ SSN _____

4. Work Phone _____ Home Phone _____ Cell Phone _____

5. Residence Address _____

City _____ State _____ ZIP _____ Years at Address _____

6. Are you a U.S. Citizen? ☐ Yes ☐ No

7. Occupation/Duties _____ Years Employed _____

8. Employer _____ Employer Phone _____

9. Employer Address _____

10. Annual Income _____ Household Income _____

Total Liabilities (debt) _____ Total Net Worth _____

11. Driver's License Number, State, and Expiration _____

B. Ownership and Beneficiary Information

1. Full Name of Owner/Trust/Corporation _____

Complete Only if Trust Owned:

a. Name of Trustee _____ Trustee SSN _____ Relationship to Trust _____

b. Trust Beneficiaries _____

c. Trust Tax ID _____ Date of Trust _____ State of Trust _____

d. Purpose of Trust _____ Type of Trust ☐ Revocable ☐ Irrevocable

Complete Only if Business Owned:

d. Purpose ☐ Buy/Sell ☐ Key Person ☐ Other _____

e. Business Tax ID _____ Corporation Contact Name _____

f. Business Address _____ Year Founded _____

g. Business Phone _____ Business Fax _____

h. Total Business Assets $_____ Total Business Liabilities $_____ Total Business Net Worth $ _____

i. Business Net Profits After Taxes: Last Year $ _____ Previous Year $_____

BENEFICIARY INFORMATION					
Beneficiary Type	Name (First, Middle, Last)	Date of Birth	Relationship to Proposed Insured	Social Security Number	Percentage of Proceeds
Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

C. EXISTING INSURANCE

Company	Amount of Insurance	Year of Issue	Type (Term, Whole Life, UL, VUL)	Policy Number	Current Premium

1. Has the proposed insured applied for any additional life insurance with another carrier? ☐Yes ☐No

   a. If yes, list company and amount _____

2. Will the applied for policy replace any of the above listed policies? ☐Yes ☐No

   a. If yes, which policy _____

   b. If yes, what is the purpose of the replacement _____

D. HEALTH, HISTORY, AND RISK

1. Name of Personal Physician _____

   a. Address _____ Phone Number _____

   b. Date Last Seen _____ Reason and Diagnosis_____

2. Height _____ Weight _____ Any Weight Change in the Past Year of 10 lbs. or Greater? _____

3. Do you or have you ever used tobacco or nicotine products in any form? ☐Yes ☐No

   a. If yes, Indicate Type _____ Amount/Frequency _____ Month/Year Last Used _____

4. Please List All Current Medications and Doses _____

5. Have you visited any other medical practitioners or specialists in the past 5 years? ☐Yes ☐No

a. Name of Doctor _____

Address _____ Phone Number _____

Date Seen _____ Reason and Diagnosis _____

d. Name of Doctor _____

Address _____ Phone Number _____

Date Seen _____ Reason and Diagnosis _____

g. Name of Doctor _____

Address _____ Phone Number _____

Date Seen _____ Reason and Diagnosis _____

	Age if Living	Health Status	Age at Death & Cause
Father			
Mother			
Sibling(s)			

6. Does the Insured plan on traveling outside the country within the next year? ☐Yes ☐No

If yes, please list destinations, length of stay, and reason _____

_____

7. Within the past three years has the Proposed Insured participated or does he/she plan to participate in any of the following: Underwater sports (scuba diving, skin diving, etc…), racing sports, sky sports, rock climbing, or any other activity that could be considered dangerous? ☐Yes ☐No

8. Has the proposed insured had any motor vehicle tickets within the past 5 years? ☐Yes ☐No

If yes, please explain _____

9. Do you exercise regularly? Please describe if Yes. ☐Yes ☐No _____

10. Does the proposed insured have any past or present health conditions that we should know about? Please let us know of anything, no matter how minor. ☐Yes ☐No

_____

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