

Date: \_\_\_\_\_

Agent Information:		
Name:	Phone #:	Alt. Phone #:
E-mail:	Relation to Insured:	Years Known:

Proposed Insured					
Name:	D.O.B.:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Height:	Weight:	Blood Pressure:
Home Phone:	Work Phone:		Cell:		
Best time to contact:	Preferred Contact Number:		E-mail:		
Driver's Lic. #:	SSN #:	US Citizen: <input type="checkbox"/> Y <input type="checkbox"/> N	Birth Place:		
Occupation:	Annual Income:		Net Worth:		

Rate & Plan Information		
Face Amount:	Plan:	Rate Class:
Modal Premium:	Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	
Payment Plan: <input type="checkbox"/> Credit <input type="checkbox"/> EFT	Riders:	
Existing Insurance:		
Do you plan to cancel another policy & replace it with this one?		
Reason for Insurance:		

Owner Information			
Is the insured the owner of the insurance policy? <input type="checkbox"/> Y <input type="checkbox"/> N <input checked="" type="checkbox"/> If yes, please skip this section. If No, please provide owner/trust information.			
Owner/Trust Name:		Trustee Name:	
Street Address:		City:	State: Zip:
Tax ID#:	Trust Date:	Trust State:	Trust Type: <input type="checkbox"/> Revocable <input type="checkbox"/> Irrevocable:

Beneficiary Information Add additional sheets as needed for additional trusts				
Primary #1:	Full Name:	Relationship:	D.O.B.	____%
	Address:		SSN #:	
Primary #2:	Full Name:	Relationship:	D.O.B.	____%
	Address:		SSN #:	
Contingent #1:	Full Name:	Relationship:	D.O.B.	____%
	Address:		SSN #:	
Contingent #2:	Full Name:	Relationship:	D.O.B.	____%
	Address:		SSN #:	

Date: \_\_\_\_\_

Client Information					
Name:			D.O.B.:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
State of Residence:		Guaranteed Term:		Coverage Amount:	Payment Mode:
Height:	Weight:	Blood Pressure:	US Citizen: <input type="checkbox"/> Y <input type="checkbox"/> N		Birth Place:

Health Information																						
1. Have you ever used tobacco products? (i.e. Cigarettes, Cigars, Pipe, Chewing Tobacco, Nicotine patch/gum)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes: Types: _____ Last Usage: ___/___/___ How often (#/day)? ___/___																				
2. Have you ever been treated for high blood pressure?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, fill out the following: Year started: ___ Pressure: ___/___ (Sys / Dia) Meds: _____																				
3. Have you ever been treated for high cholesterol?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, fill out the following: Year started: ___ Levels: ___/___ (Total/HDL) Meds Taken: _____																				
4. Do you participate in any hazardous activities? (i.e. Skydiving, scuba, pilot, racing, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, please list activities, how often & dates: _____																				
5. Have you ever been convicted of drunk driving DUI/DWI, reckless driving, or had your license suspended or revoked?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, date of conviction: _____																				
6. Have you received any moving violations/tickets (not parking tickets) within the last 5 years?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, please list all and date: _____																				
7. Have you ever been declined for life insurance?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input checked="" type="checkbox"/> If yes, why? _____																				
<p>8. Have you ever been treated for any of the following conditions? (Check all that apply):</p> <table border="0"> <tr> <td><input type="checkbox"/> Alcohol/Drugs</td> <td><input type="checkbox"/> Colitis / Crohn's Disease</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> Sleep Apnea</td> </tr> <tr> <td><input type="checkbox"/> Alzheimer's Disease</td> <td><input type="checkbox"/> Depression</td> <td><input type="checkbox"/> Kidney / Liver Disease</td> <td><input type="checkbox"/> Stroke</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Mental Illness</td> <td><input type="checkbox"/> Ulcerative Colitis or Ileitis</td> </tr> <tr> <td><input type="checkbox"/> Cancer: _____</td> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Multiple Sclerosis</td> <td><input type="checkbox"/> Vascular Disease</td> </tr> <tr> <td><input type="checkbox"/> COPD</td> <td><input type="checkbox"/> Emphysema</td> <td><input type="checkbox"/> Rheumatoid Arthritis</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>If yes, please list the condition, date(s) of diagnosis and treatment, and any medications currently being used.</p> <p>_____</p> <p>_____</p> <p>_____</p>			<input type="checkbox"/> Alcohol/Drugs	<input type="checkbox"/> Colitis / Crohn's Disease	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney / Liver Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Ulcerative Colitis or Ileitis	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> COPD	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other: _____
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Family History					
	Age OR Age of death (if deceased)	Cause of death (if deceased)	History of heart or circulatory disease	History of cancer (all types)	Notes:
Mother			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Father			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Sister(s)			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Brother(s)			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	