

PROPOSED INSURED INFORMATION

First Name: _____ **Middle Int.:** _____ **Last Name:** _____

State: _____ **D.O.B:** _____ **Gender (M or F):** _____ **Coverage Amount:** _____

Term Years: _____ **Is this a replacement? (Y or N):** _____ **Will the insured own this policy? (Y or N):** _____

Riders: Accidental Death Benefit (Y or N): _____ Waiver of Premium _____ Child Term _____

Amount: (\$1,000 increments up to \$25,000) _____

CLIENT INFORMATION INFORMATION

SSN # _____ **Home Phone#** _____ **Driver's License #** _____ **License State:** _____

Email Address _____ **Address** _____

City _____ **State:** _____ **Zip:** _____

Owner's Full Name (If other than insured) _____ **D.O.B:** (or Trust Date) _____

SSN/TIN # _____ **Relationship** _____ **Email Address** _____

Address (If other than insured) _____ **City** _____ **State:** _____ **Zip:** _____

Is the client a U.S. Citizen? (Y or N): _____ **Purpose of Insurance (Personal or Business):** _____

Income: \$ _____ **Networth:** \$ _____ **Assets:** \$ _____

EXISTING/PENDING COVERAGE

Does the client have any existing or pending life insurance or annuities? If yes, please fill in the fields below.

Carrier	Amount	Policy Number	Issue Year	Beneficiary	Replacement (Y or N):
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your exist policy or contract? (Y or N): _____

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy/contract? (Y or N): _____

Reason for replacement: _____

BENEFICIARY INFORMATION

Name/Relationship	Primary/Contingent	Percent	DOB	SSN # / TIN #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

AGENT ONLY SECTION

What is the source of funds for the initial premium? _____

What is the source of funds for future premiums? _____

Did you see the proposed insured at point-of-sale? (Y or N): _____

Is the proposed insured an active duty service member of the US Armed Forces (including National Guard and Reserve)? (Y or N): _____

Is the policyowner, or the person to whom this policy was sold, an active duty service member of the United States Armed Forces (including National Guard and Reserve)? (Y or N): _____

HEALTH INFORMATION

Height _____ Weight _____ (current weight plus 1/2 of any weight loss in the last year)

Does the proposed insured use or have they ever used tobacco/nicotine? (Y or N): _____

If yes, what type, frequency and when last used? _____

If cigar use will the insured test positive for nicotine? _____

Has any parent or sibling of the proposed insured had, been diagnosed with, or died from cardiovascular disease and/or cancer prior to age 65? (Y or N): _____ If yes, fill out the following for each applicable parent and/or sibling:

Relationship	Age at Death/Diagnosis	Carrier	Result (Death or Diagnosis)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has the client ever been told he/she has high blood pressure (hypertension)? (Y or N): _____

Does the client currently take medication or have any history or treatment for high blood pressure? (Y or N): _____

If yes, what was the client's usual blood pressure reading for the past 6 months? _____ / _____

If the client does not know his/her reading, select the option that best describes his/her blood pressure over the past 12 months (very well-controlled, reasonably well-controlled, or not well-controlled)? _____

Has the client had more than 3 speeding tickets and/or moving violations in the past 3 years; OR had a DUI, license suspension, or revocation in the past 5 years? (Y or N): _____

Has the client ever been diagnosed with, or received treatment/advice for, any of the following?

- | | | | |
|--------------------|-------------------------|--|---------------------------|
| AIDS, ARC, HIV | Multiple Sclerosis (MS) | Peripheral Artery/Vascular Disease (PAD)/(PVD) | Rheumatoid Arthritis (RA) |
| Emphysema/COPD | Barrett's Esophagus | Cancer (except certain skin cancers) Heart Valve Replacement | Crohn's Disease |
| Liver Failure | Heart Disease | Heart Failure | Hepatitis B |
| Alcoholism | Parkinson's Disease | Hepatitis C (active) | Sleep Apnea |
| Epilepsy/Seizure | Bipolar Disease | | Diabetes |
| Drug Abuse | Ischemic Attack (TIA) | | Stroke/Transient |
| Ulcerative Colitis | | | Kidney Disease |

If yes, please provide details: _____

Has the proposed insured used marijuana in the last 5 years? If yes, frequency and type: _____