

## Primary Insured

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First Name

Middle Name

Last Name

DOB

Gender

SSN

Marital Status

Birth Country

Birth State

City of Birth

U.S. Citizen?

Annual Income

Net Worth

Address

Years At Address   E-mail Address

Best Contact Number

## Build Information

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Height

Weight

In the past year, has there been a weight loss of 15 or more pounds for reasons other than intentional diet and/or exercise or pregnancy and delivery?

## Driving Information

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In the past 5 years, have you been convicted of driving under the influence or driving while impaired?

Drivers License Number	Drivers License State	Drivers License Expiration Date
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## Employment Information

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Currently Employed?	Type of Business	Current Employer Name
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Current Employer Address

Occupation/Job Title

Job Duties

Duration of Employment

## Tobacco Information

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Have you ever used tobacco or nicotine in any form including, but not limited to chewing tobacco; snuff; cigars; cigarettes; pipes; electronic cigarettes; vaporizer (vape); nicotine gum; or patches?

## Owner Information

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Is the insured the owner?

If No, who will be the owner?

Beneficiary Name

Beneficiary DOB

Beneficiary SSN

## Existing Insurance and Replacements

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Do you have existing life insurance or annuity coverage with this, or any other company?

*If yes:*

Policy Carrier

Policy Number

Death Benefit

Purpose

Date Issued

In the past 6 months, has any proposed insured applied for - or is any proposed insured currently contemplating applying for - other life insurance with this, or any other company?

## Purpose of Coverage

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Please check all that apply.

### **Personal:**

Income Replacement

Debt Repayment

Estate Planning/Conservation

Other

### **Business:**

Key Person

Buy-Sell

Deferred Compensation

Loan Protection

Other

## Premium Information

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Is the insured the payor?

*If No:*

Payor Name

Payor Address

Premium Mode

Would you like to pay by check or EFT?

*If EFT:*

Routing Number

Account Number

Bank Name

Branch Location

Address

## Physician/ Facility that has Most Complete Medical Records

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Physician/Facility Name

Phone

Address

Date Last Seen

Reason For Most Reason Visit

## Family History

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### Father

Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?

*If yes, add age of diagnosis:*

Is Father deceased?

*If yes:*

Age of Death

Cause of Death

### Mother

Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma?

*If yes, add age of diagnosis:*

Is Mother deceased?

*If yes:*

Age of Death

Cause of Death

Do you have any siblings?

If yes, how many?

*For each sibling, please answer:*

**Any history of heart disease, stroke, breast cancer, colon cancer, lung cancer, prostate cancer or melanoma? If yes, add the age of diagnosis below.**

Sibling 1

Sibling 2

Sibling 3

Sibling 4

Sibling 5

AGE

AGE

AGE

AGE

AGE

**Is this sibling deceased? If yes, add the age of death below.**

Sibling 1

Sibling 2

Sibling 3

Sibling 4

Sibling 5

AGE

AGE

AGE

AGE

AGE

For additional siblings, please list information below.

## Medical History

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Has any proposed insured EVER been diagnosed or treated by a licensed member of the medical profession for AIDS and/or the HIV infection?

Has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...

Heart disease, including: heart attack; coronary artery blockage; angina; heart failure; cardiomyopathy; irregular heartbeat; or disease or disorder of the heart?

Stroke, Transient Ischemic Attack (TIA/mini-stroke), carotid artery disease, peripheral vascular disease, poor circulation, aneurysm, or any other disease or disorder of the blood vessels?

Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia?

Anemia, clotting disorder, or any disease or disorder of the blood (excluding a positive HIV test)?

Any diseases or disorders of the immune system except for those related to the HIV infection?

## Medical History Last 10 Years

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In the past 10 YEARS, has any proposed insured EVER been diagnosed, received treatment for, or been advised by a member of the medical profession to seek treatment regarding...

High blood pressure?

Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar?

Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment?

Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs?

Gastrointestinal bleeding, ulcers, Crohn's disease, Barrett's esophagus, ulcerative colitis, hepatitis, cirrhosis, colon polyps, or any other disease or disorder of the esophagus, stomach, intestines/colon, rectum, liver or pancreas?

Any disease or disorder of the kidneys, urinary bladder, blood in urine, protein in urine, prostate disorder including abnormal PSA (prostate specific antigen), ovaries, uterus, or cervix including abnormal Pap smear?

Disorder of the thyroid, pituitary gland, parathyroid gland, or adrenal glands?

Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition?

Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder?

Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system?

## Medical History Last 5 Years

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In the past 5 YEARS, has any proposed insured...

Had any consultation, testing, surgery or investigation scheduled or recommended by a member of the medical profession that has not yet been completed (excluding routine checkups, preventative care, pregnancy and HIV)?

Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source?

Taken any prescription medications other than what has already been disclosed on the application?

## Drug/Alcohol History

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In the past 10 YEARS, has any proposed insured...

Used marijuana in any form?

Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens, or any other controlled substance not prescribed by a physician?

Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs?

Been advised by a licensed medical professional to cease or reduce alcohol use or been advised to get medical treatment, or undergone any medical treatment, counseling, or hospitalization for alcoholism, excessive alcohol use or abuse?

## Insurance History and Non-Medical Hazards

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In the past 5 years, has any proposed insured applied for life, accident or health insurance or for reinstatement of any such insurance that was declined, postponed, canceled or withdrawn, or modified as to plan, amount or rate?

In the past 5 years, has any proposed insured engaged in - or within the next 2 years does any proposed insured intend to engage in - flights as a pilot, student pilot, crew member, or observer?



In the past 5 years, has any proposed insured engaged in - or within the next 2 years does any proposed insured intend to engage in - mountain climbing, rock climbing, racing, SCUBA diving, hang gliding, ballooning or sky diving?

In the past 10 years, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending?

In the past 12 months, has any proposed insured been or are you currently on probation or parole?

Do you intend to travel or reside outside of the U.S. or Canada in the next 2 years?

***If any yes to medical information question, please provide details below.***