Life Insurance Application

Required Information

Make sure you get a copy of photo ID!

If owner is different then insured add to notes

Owner/Insured Information

Name (First, Middle, Last): _____

Sex: _____ DOB: _____ SSN: _____

City of Birth: _____ Place of Birth (State/Country): _____

Address: _____

How long have you lived here _____

Work Phone: _____ Cell Phone: _____ Email: _____

Drivers License #: _____ Issue State: _____ Issue Date: _____ Exp Date: _____

Citizenship: _____ Perm. Residence Card # or Visa _____

Employer name & Time employed (until now): _____

Occupation: _____ Brief description of job duties: _____

Annual Income: _____ Networth: _____

Marital Status: _____ Total Net Worth: _____

Beneficiary(ies) info for each of them

Beneficiary 1

☐ Primary ☐ Contingent Distr. %: _____

Full Name: _____

Relationship: _____

Address: _____

_____

Phone #: _____ Email: _____

SSN: _____ DOB: _____

Beneficiary 2

☐ Primary ☐ Contingent Distr. %: _____

Full Name: _____

Relationship: _____

Address: _____

_____

Phone #: _____ Email: _____

SSN: _____ DOB: _____

Beneficiary 3

☐ Primary ☐ Contingent Distr. %: _____

Full Name: _____

Relationship: _____

Address: _____

_____

Phone #: _____ Email: _____

SSN: _____ DOB: _____

Beneficiary 4

☐ Primary ☐ Contingent Distr. %: _____

Full Name: _____

Relationship: _____

Address: _____

_____

Phone #: _____ Email: _____

SSN: _____ DOB: _____

Premium Information

Premium Mode: Monthly Quarterly Semi-Annual Annual _____

If monthly was selected, indicate draft date (from 1st-30th):

Bank information Bank name: _____

Bank routing #: _____

Bank account #: _____

Information regarding exisiting policies

If you currently have any in-force Life Insurance or Annuity contract incl. Long Term insurance or Rider, please provide details of each policy:

Policy 1

Company name: _____ Policy #: _____

Date issued: _____ Amount of coverage: _____ ADB coverage: _____

Is the existing policy going to be replaced? Yes or No _____

1035 Exchange ? Yes or No _____

(Transfer all the cash value from the current policy to the new policy)

Policy 2

Company name: _____ Policy #: _____

Date issued: _____ Amount of coverage: _____ ADB coverage: _____

Is the existing policy going to be replaced? Yes or No _____

1035 Exchange ? Yes or No _____

(Transfer all the cash value from the current policy to the new policy)

Policy 3

Company name: _____ Policy #: _____

Date issued: _____ Amount of coverage: _____ ADB coverage: _____

Is the existing policy going to be replaced? Yes or No _____

1035 Exchange ? Yes or No _____

(Transfer all the cash value from the current policy to the new policy)

Policy 4

Company name: _____ Policy #: _____

Date issued: _____ Amount of coverage: _____ ADB coverage: _____

Is the existing policy going to be replaced? Yes or No _____

1035 Exchange ? Yes or No _____

(Transfer all the cash value from the current policy to the new policy)

Health History

Doctor name: _____

Doctor address: _____

Date of last Doctor visit: _____

Reason for this visit and outcome: _____

Height: _____ Weight: _____

Have you gained or loss weight within the last 12 months: Yes or No _____

Reason: _____

Do you currently take any medicines? If yes, list the name and dosage, also why you take it.

Do you have any health issues that you need to declare? If so indicate them on the line below

_____

_____

Is your father alive? If yes, his current age: _____

If no, indicate age of death and reason of death:

_____

Is your mother alive? If yes, her current age: _____

If no, indicate age of death and reason of death:

_____

Do you smoke: Yes or No _____

Notes

Medical Section

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)?	☐ Yes	☐ No
Applied for or received any disability benefits (other than maternity) from any insurance company, government, employer, or other source?	☐ Yes	☐ No
Taken any prescription medications other than what has already been disclosed on the application?	☐ Yes	☐ No

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?	☐ Yes	☐ No
Diabetes or abnormal blood sugar to include high blood sugar or low blood sugar?	☐ Yes	☐ No
Depression, anxiety, attention deficit/hyperactivity disorder, bipolar disorder, schizophrenia, post-traumatic stress disorder, or psychiatric treatment?	☐ Yes	☐ No
Asthma, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), emphysema, sleep apnea, tuberculosis, or any disease or disorder of the lungs?	☐ Yes	☐ No
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?	☐ Yes	☐ No
Has any proposed insured EVER been diagnosed or treated by a licensed member of the medical profession for AIDS and/or the HIV infection?	☐ Yes	☐ No
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?	☐ Yes	☐ No
Disorder of the thyroid, pituitary gland, parathyroid gland, or adrenal glands?	☐ Yes	☐ No
Arthritis, fibromyalgia, chronic pain, chronic back pain, or any joint or muscle condition?	☐ Yes	☐ No
Lupus, scleroderma, any connective tissue disease, or any autoimmune disorder?	☐ Yes	☐ No
Seizures/epilepsy, tremors, multiple sclerosis, paralysis, Alzheimer's, dementia, Parkinson's, blindness or any other disease or disorder of the brain or nervous system?	☐ Yes	☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Cancer, tumor, abnormal growth, lump, mass, melanoma, lymphoma, or leukemia? ☐ Yes ☐ No

Anemia, clotting disorder, or any disease or disorder of the blood (excluding a positive HIV test)? ☐ Yes ☐ No

Any diseases or disorders of the immune system except for those related to the HIV infection? ☐ Yes ☐ No

In the past 10 YEARS, has any proposed insured…

Used marijuana in any form? ☐ Yes ☐ No

Used cocaine, barbiturates, crack, ecstasy, methamphetamine, heroin, LSD or hallucinogens, or any other controlled substance not prescribed by a physician? ☐ Yes ☐ No

Been addicted to prescription medication or been advised by a licensed medical professional to discontinue habit forming drugs? ☐ Yes ☐ No

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? ☐ Yes ☐ No

Insurance History and Non-Medical Hazards

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, cancelled or withdrawn, or modified as to plan, amount or rate? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

In the past 10 years, has any proposed insured plead guilty or been convicted of a felony or have any felony charges currently pending? ☐ Yes ☐ No

In the past 12 months, has any proposed insured been or are you currently on probation or parole? ☐ Yes ☐ No

Do you intend to travel or reside outside of the U.S. or Canada in the next 2 years? ☐ Yes ☐ No