PROPOSED INSURED INFORMATION

State: _____ DOB: __/__/____ Gender: ○ M ○ F Coverage Amount: $ _____

Term Years: _____ Is this a replacement? ○ Y ○ N Will the insured own this policy? ○ Y ○ N

Riders: ☐ Waiver of Premium ☐ Accidental Death Benefit ☐ Child Term Amount $ _____ ($1,000 increments up to $25,000)

HEALTH INFORMATION

1.) Height: _____ feet _____ inches 2.) Weight: _____ lbs

3.) Does the proposed insured use or have they ever used tobacco or nicotine? Please Select...

3a.) If so, which statement best matches the proposed insured's usage? Please Select...

4.) 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? *If yes, fill out the following for each applicable parent and/or sibling:* ○ Y ○ N

Relationship	Age at Death or Diagnosis	Type: Cardiovascular or Cancer	Result: Death or Diagnosis
_____	_____	Please Select...	○ Death ○ Diagnosis
_____	_____	Please Select...	○ Death ○ Diagnosis
_____	_____	Please Select...	○ Death ○ Diagnosis
_____	_____	Please Select...	○ Death ○ Diagnosis

5.) Has the client ever been told he/she has high blood pressure (hypertension)? ○ Y ○ N

5a.) If yes, what was the client's usual blood pressure reading for the past 6 months? ____ / ____

5b.) Is the client on blood pressure medication? ○ Y ○ N

5c.) 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
○ not well-controlled

6.) 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 ○ N

7.) Has the client ever been diagnosed with, or received treatment/advice for, any of the following? ○ Y ○ N

- AIDs, ARC, HIV+
- Multiple Strokes
- Kidney Failure
- Heart Valve Replacement
- Heart Failure
- Emphysema
- Multiple Heart Attacks
- Diabetes
- Hepatitis "C" Active
- Liver Failure
- ALS (Lou Gehrig's Disease)
- Sleep Apnea

8.) In the past 10 years, has the client been diagnosed with, or received treatment/advice for, any of the following? ○ Y ○ N

- Alcoholism
- Heart Disease
- Stroke
- Drug Abuse
- Heart Attack
- Cancer (except certain skin cancers)
- Multiple Sclerosis

9.) Has the client ever had an application for life or health insurance declined, postponed, modified, or rated or offered other than as applied for? ○ Y ○ N

10.) Has the client ever been diagnosed with, or received treatment or advice for, any condition other than those in questions 7 and 8, or is the client currently taking any medications? (If yes, provide details):

_____

CLIENT INFORMATION

How will your client (owner if different from insured) sign the application and required forms? ○ E-Signature ○ Traditional

FIRST NAME _____ MIDDLE _____ LAST _____ SOCIAL SECURITY # ___ - ___ - _____ EMAIL ADDRESS _____

HOME PHONE (___) ___ - _____ CELL PHONE (___) ___ - _____ WORK PHONE (___) ___ - _____ DRIVER'S LICENSE # _____ LICENSE STATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

OWNER FULL NAME (IF OTHER THAN INSURED) _____ DOB OR TRUST DATE ___ / ___ / _____ SOCIAL SECURITY # / TIN # ___ - ___ - _____ RELATIONSHIP _____ EMAIL ADDRESS _____

PERSONAL INCOME $ _____ HOUSEHOLD INCOME $ _____ ASSETS $ _____ LIABILITIES $ _____

Is the client a U.S. Citizen? ○ Y ○ N Purpose of Insurance: ○ Personal ○ Business Reason: Please Select...

What is the source of funds for the initial premium? Please Select...

What is the source of funds for future premiums? Please Select...

Did you see the proposed insured at point-of-sale? ○ Y ○ N

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

EXISTING/PENDING COVERAGE

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

Carrier	Amount	Policy Number	Issue Year	Beneficiary	To Be Replaced?
_____	$ _____	_____	_____	_____	○ Y ○ N
_____	$ _____	_____	_____	_____	○ Y ○ N

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

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ○ Y ○ N

Reason for replacement: _____

Total Accidental Death insurance inforce with all companies: $ _____

BENEFICIARY INFORMATION

Name/Relationship	Primary/Contingent	Percent	DOB	Social Security/TIN #
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____