Client Name: _____ **DOB:** _____ Male ☐ Female ☐

SSN: __ _____ **Client Phone #:** _____ _____
Main # Secondary #

United States Citizen? Yes ☐ No ☐ If no, citizen of which country: _____

Address: _____ _____ _____ _____
Street Address City State Zip

Beneficiary Name: _____ **Relationship:** _____

Carrier: _____ **Face Amount $** _____ Length of term _____ years

Has the proposed insured ever used tobacco in any form? Yes ☐ No ☐ What Type: _____

Last used: 12 months ☐ 36 months ☐ 5 years ☐ More: ☐ _____ years

Current Height: _____ Feet _____ Inches **Current Weight:** _____ Lbs.

Current Occupation: _____

Does the proposed insured participate in piloting an aircraft, scuba diving, motor vehicle racing, etc.?

No ☐ Yes ☐ If yes, provide details: _____

Has proposed insured traveled out of the US in the past 12 months or plan to in the next 12 months?

No ☐ Yes ☐ If yes, provide details: City _____ Country _____

Reason for travel _____ Length of stay _____

Is proposed insured taking any prescription medications?

No ☐ Yes ☐ If yes, detail _____

Does the proposed insured consume alcoholic beverages?

No ☐ Yes ☐ If yes, provide how often and what type _____

Does the proposed insured have a history of alcohol or substance abuse?

No ☐ Yes ☐ If yes detail: _____

Do the proposed insured have any DWI or DUI convictions in the past?

No ☐ Yes ☐ If yes, date(s) _____

Has the proposed insured had more than 2 motor vehicle moving violations in the past 3 years?

No ☐ Yes ☐

Has either parent or sibling had a history of cardiovascular disease or cancer before age 60:

No ☐ Yes ☐ If yes, detail: _____

Currently any Life Insurance inforce? No ☐ Yes ☐

If so please provide details _____

Will this policy be a replacement of any current coverage? No ☐ Yes ☐

Will the insured (you) be the owner of this policy? No ☐ Yes ☐

If No, the owner of this policy will be: _____

Relationship to the insured is: _____

Owner's Social Security Number: _____

Or Tax ID Number _____

Owner's Address: _____

Owner's City: _____ State: _____ Zip: _____

Name of authorized signor: _____

What is the purpose of the insurance?

☐ **Personal** (family protection, income replacement, estate planning)

Gross annual income of the client:_____Household Income: _____

Total Assets: _____ Total Liabilities: _____

Liabilities and Net Worth of the company: _____

% of client ownership , if any: _____

Gross annual salary of client: _____

Any applied for or inforce on other key members of the business? No ☐ Yes ☐

Agent name: _____ **Phone number:** _____

Agent email address: _____

PLEASE NOTE: Completing this form does not constitute any coverage. Coverage will not begin until underwriting is complete and accepted.