Client Data Form

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 *(current weight plus 1/2 of any weight loss in the last year)*

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

3a.) If yes, what type, frequency and when last used? _____

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
_____	_____	_____	○ Death ○ Diagnosis
_____	_____	_____	○ Death ○ Diagnosis
_____	_____	_____	○ Death ○ Diagnosis
_____	_____	_____	○ Death ○ Diagnosis

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

5a.) Does the client currently take medication or have any history or treatment for high blood pressure? ○ Y ○ N

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

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 positive
Emphysema/COPD
Liver Failure
Alcoholism
Epilepsy/Seizure Lupus
ALS (Lou Gehrig's Disease)
Gastric Bypass/Lap Band
Melanoma
Atrial Fibrillation Heart Attack
Multiple Sclerosis (MS)
Barrett's Esophagus
Heart Disease
Parkinson's Disease
Bipolar Disease
Heart Failure
Peripheral Artery/Vascular Disease (PAD)/(PVD)
Cancer (except certain skin cancers)
Heart Valve Replacement
Rheumatoid Arthritis (RA)
Crohn's Disease
Hepatitis B
Sleep Apnea
Diabetes
Hepatitis C (active)
Stroke/Transient Ischemic Attack (TIA)
Drug Abuse
Kidney Disease
Ulcerative Colitis (UC)

8.) Has the proposed insured used marijuana in the last 5 years? ○ Y ○ N

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

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CLIENT INFORMATION

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

First Name _____ Middle Int. _____ Last _____ SSN # ___ - ___ - _____ Email Address _____

Home Phone (___) ___ - _____ Mobile Phone (___) ___ - _____ Work Phone (___) ___ - _____ Driver's License # _____ License State _____

Address _____ City _____ State _____ Zip _____

Owner's Full Name _____ *(If other than insured)* DOB or Trust Date ___ / ___ / _____ SSN # / TIN # ___ - ___ - _____ Relationship _____ Email Address _____

Personal Income $_____ Household Income $_____ Assets $_____ Liabilities $_____

Is the client a U.S. Citizen? ◯ Y ◯ N Purpose of Insurance: ◯ Personal ◯ Business

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 ◯ 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	Replacement
_____	$_____	_____	_____	_____	◯ 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	SSN # / TIN #
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____
_____	_____	_____	___ / ___ / _____	___ - ___ - _____