

1. Do you own life Insurance? **Yes** **No**
 - i. If Yes:
 1. What company is the coverage with?
 2. How much coverage?
 3. What is the premium?
 4. When did the policy start?
 5. What is the date the policy ends?
 6. Any cash value? **Yes** **No**
 - a. Cash Value amount:
 - b. Please get a copy of a current statement
2. What is your annual income. If married complete for each.
 - a. Spouse 1 Name and income
 - b. Spouse 2 Name and income
3. Do you have Children? If yes provide ages:
 - a. Would you like to discuss college saving options? **YES** **NO**
4. What age would you like to retire?
5. Would you like coverage past retirement ? **YES** **NO**
6. Would you like to look at policies that can provide cash accumulation? **YES** **NO**
7. Would you like to look at insurance that replaces your income if you were to get hurt or sick? **YES** **NO**
8. Would you like to review solutions to assisting with Long term care needs. **YES** **NO**

Name *

Sex *

Male Female

Phone *

Email *

Resident City and State

Zip Code

Occupation

Currently Employed

Yes No

Date of Birth

Height

Weight

Any weight change in the last year?

Yes No

Amount of weight change

Amount of coverage and term length?

Are you a tobacco user? Quit? Type

Yes No Yes No

Amount Month/Year Quit

If you are a current tobacco use, what is the last time and what type and amount do you normally consume?

Marijuana Use

Do you currently use Marijuana?

Yes No

If yes, please list frequency, daily, weekly, monthly?

Have you ever been treated for or been told you had: (Please check all conditions that apply, the year they were diagnosed and any helpful details like stage and grade of cancer or A1c if diabetic, mild, moderate or severe sleep apnea, etc)

- 1) Convulsions, epilepsy, paralysis, mental or nervous disorder?
- 2) Chest pain, high blood pressure, heart murmur, heart attack, stroke, cholesterol, or disorder of the heart or circulatory system?
- 3) Asthma, emphysema, bronchitis, tuberculosis, sleep apnea, or chronic respiratory disease?
- 4) Jaundice, intestinal bleeding, ulcer, chronic colitis, diverticulitis, or other liver or gastro-intestinal disorder?
- 5) Complicated pregnancy, hysterectomy, disorder of the breast or female organs?
- 6) Disease of the kidney, bladder, prostate, sugar or protein in the urine?
- 7) Loss of vision, amputation, deformity, arthritis, or any disorder of the muscles, bones or joints?
- 8) Cancer, tumor, diabetes (will need current A1C reading), or glandular disorder?
- 9) Treated for drug addiction, alcoholism, or been a member of AA?

10) In the past 10 years, have you been treated for AIDS or AIDS related complex?

11) Had a parent, brother, or sister who had cancer, diabetes, heart disease or who committed suicide? (Please list age of onset and/or death)

12) In the past five years, have you participated in or do you intend to participate in: any flights as a trainee, pilot or crew member, scuba diving or parachuting, ultra light aviation, auto racing, cave exploration, hang gliding, boat racing, mountaineering, extreme sports, or other hazardous activities? (Please provide full details below, such as hours, ratings, equipment used, etc).

13) in the past five years, have you ever had any traffic violations?

14) Ever been charged with or convicted of a DUI, reckless driving, or had your license revoked or restricted?

15) Are you currently on any prescription medication? (Please list all, including dosage)

16) Do you travel or intend to travel outside the US or Canada, for business or pleasure? (Please provide city, country, reasons and length of stay)

17) In the past five years, have you filed for bankruptcy or had any judgements or liens against you?

Details (Please be very specific about information provided. Understand that the formal application will include a review of your medical records and if necessary the records from anyone your primary care doctor has referred you to. The best way to put this is let's get all of the information on the table now and that will help ensure a more accurate quote).

Question #	Year of diagnosis or treatment: Details or reasons:
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Additonal Comments: