

*This is not an application for life insurance. The informal application is used exclusively to gather specific details on a proposed insured's medical history and other factors that may impact underwriting and rating classifications.*

Today's Date: \_\_\_\_\_

**Agent Information (Required)**

Name: \_\_\_\_\_ Tel. #: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insured Information (Required)**

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Male Female  
Address: \_\_\_\_\_  
Primary tel. #: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Monthly income: \_\_\_\_\_ Total net worth: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Driver's license #: \_\_\_\_\_ State \_\_\_\_\_ Expiration date: \_\_\_\_\_  
Are you a US Citizen Yes No If no, Visa type: \_\_\_\_\_  
Have you or do you intend to travel outside of the US in the past/next 12 months? Yes No  
If yes, please provide details of travel: \_\_\_\_\_  
\_\_\_\_\_

**Plan Information**

Plan of insurance you are inquiring about:  
Whole Life Universal Life Term Life: (Duration \_\_\_\_\_) Survivorship Variable  
Face amount: \_\_\_\_\_ Premium budget: \_\_\_\_\_ Premium mode: \_\_\_\_\_  
Sate of sale: \_\_\_\_\_ Purpose of insurance: \_\_\_\_\_  
Any life, disability, or annuity policies currently in-force?: Yes No

Carrier	Face Amount	Year Issued	Premium	Replacement	Owner/Purpose

Has this case been submitted to other companies in the past 12 months?      Yes      No (If yes, please list below):

Company: \_\_\_\_\_ Date submitted: \_\_\_\_\_

Action Taken: \_\_\_\_\_

Company: \_\_\_\_\_ Date submitted: \_\_\_\_\_

Action Taken: \_\_\_\_\_

Company: \_\_\_\_\_ Date submitted: \_\_\_\_\_

Action Taken: \_\_\_\_\_

## Tobacco/Nicotine Use

Have you ever used any kind of tobacco product?      Yes      No

If yes, forms used:      Cigarettes      Cigars      Pipe      Dip/chew      Nicotine Gum      E-Cigarette/vape

Other \_\_\_\_\_

Frequency: \_\_\_\_\_ Date of last usage: \_\_\_\_\_

## Drug/Alcohol Use

Do you currently drink alcohol?      Yes      No      Date of last consumption: \_\_\_\_\_

Type of Alcohol: \_\_\_\_\_ Frequency: \_\_\_\_\_

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Have you ever consulted a doctor or received treatment for alcohol abuse?      Yes      No

Have you ever been arrested for driving under the influence of alcohol?      Yes      No (If Yes, date: \_\_\_\_\_)

Have you ever used illegal drugs, consulted a doctor, or received treatment for drug abuse?      Yes      No

Types of Drugs Used: \_\_\_\_\_

Date(s) Last Used: \_\_\_\_\_ Are you currently involved in a 12-Step Program?      Yes      No

## Marijuana Use

Have you ever used any kind of marijuana/CBD product?      Yes      No

If yes, reason for use:      Recreational      Medicinal

Delivery method:      Ingested      Vaporized      Smoked      Other \_\_\_\_\_

Frequency: \_\_\_\_\_ Date of last usage: \_\_\_\_\_

If medicinal, reason prescribed \_\_\_\_\_ Frequency: \_\_\_\_\_

## Hazardous Activities - Only complete if applicable

Are you a pilot?      Yes      No (If Yes, please provide details below):

How many total hours have you flown as Pilot in Command? \_\_\_\_\_ How many hours do you fly per year? \_\_\_\_\_

Are you IFR (Instrument Flight Rated)?      Yes      No

Do you participate in any of the following activities? (Check all that apply)

Scuba Diving      Bungee Jumping      Ultralight Flying      Sky Diving      Mountain Climbing  
 Hang Gliding      Auto Racing      Motorcycle Racing      Other (details): \_\_\_\_\_

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*If you checked any of the above activities please contact our New Business department for additional forms that may be required to complete the underwriting assessment.*

## Medical Information

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Have you had any significant weight change (10 lbs. or more) over the last 12 months?      Yes      No

If yes, please explain reason for weight change: \_\_\_\_\_

Blood Pressure and Cholesterol:

Latest BP reading: \_\_\_\_\_ / \_\_\_\_\_ Latest total cholesterol: \_\_\_\_\_ mg; Latest cholesterol/HDL ratio: \_\_\_\_\_

Have you ever had, been told you had, or been treated for any of the conditions listed? (check all that apply)

## Doctor Information

Dementia/cognitive impairment	Depression/anxiety	Lupus
Asthma	Diabetes	Multiple sclerosis
Cancer	Drug abuse	Peripheral vascular disease
Cirrhosis	Heart murmur/valve disease	Rheumatoid arthritis
COPD	Hepatitis	Seizure
Coronary artery disease	Internal organ transplant	Sleep apnea
Cerebrovascular disease	Irregular heartbeat/palpitations	Stroke or TIA
Colitis or Crohn's disease	Kidney disease	Other _____

Primary care physician's name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. #: \_\_\_\_\_

Date last seen: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Please list all doctors seen in the last 5 years along with reason for visit:

Name/specialty: \_\_\_\_\_ City, State: \_\_\_\_\_

Tel. #: \_\_\_\_\_ Date seen/reason: \_\_\_\_\_

Name/specialty: \_\_\_\_\_ City, State: \_\_\_\_\_

Tel. #: \_\_\_\_\_ Date seen/reason: \_\_\_\_\_

Name/specialty: \_\_\_\_\_ City, State: \_\_\_\_\_

Tel. #: \_\_\_\_\_ Date seen/reason: \_\_\_\_\_

List all medication you have been prescribed in the last 12 months and include dosage:

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## Family History

Has any immediate family member (parent/sibling) been diagnosed or died from heart disease, cancer, stroke or diabetes?

Yes      No      If yes, please provide details:

Relation: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Age at onset: \_\_\_\_\_ Age at death (if applicable): \_\_\_\_\_

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Age at onset: \_\_\_\_\_ Age at death (if applicable): \_\_\_\_\_

## Coronary Artery Disease - Only complete if applicable

Date of diagnosis or first chest pain: \_\_\_\_\_ Number of Diseased Vessels: \_\_\_\_\_

Dates/details or treatments/surgery (example: Angioplasty, Bypass): \_\_\_\_\_

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Date of last stress EKG: \_\_\_\_\_ Results: \_\_\_\_\_

Physician that completed: \_\_\_\_\_

City/State of physician: \_\_\_\_\_ Tel. #: \_\_\_\_\_

Any pain since treatment/surgery?      Yes      No

## Cancer - Only complete if applicable

Exact name and location of cancer: \_\_\_\_\_

Stage and grade: \_\_\_\_\_

Physician contact information to obtain pathology report: \_\_\_\_\_

Dates/details or treatment/surgery: \_\_\_\_\_

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**Diabetes** - Only complete if applicable

Date of Diagnosis: \_\_\_\_\_

Treatment: (Check all that apply)

Diet only      Oral medication      Insulin      Other (specify) \_\_\_\_\_

Do you regularly test your blood for glucose?      Yes      No      Frequency: \_\_\_\_\_ Avg Result: \_\_\_\_\_

Latest result of glycohemoglobin (A1C) test: \_\_\_\_\_ mg%

Have you ever had any of the following? (Check all that apply)

Eye Trouble      Heart Trouble      High Blood Pressure      Kidney Trouble  
Neuropathy/Neuralgia      Insulin Reaction (Explain below)      Protein/Microalbumin

\_\_\_\_\_  
\_\_\_\_\_

Please provide any additional information you feel necessary to enhance our underwriting process.

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