Life Insurance

GENERAL INFORMATION PACKAGE

(Please fill out the information to the best of your ability.)

APPLICANT INFORMATION		
Name (First, Middle, Last):		
Date of birth :	SSN:	Sex:
Address (Street, City, State, & Zip):		
Age:	Phone:	Email:
Height:	Weight:	
Driver ID # & State:		
Are you a citizen of the USA (Yes or No. If No, please elaborate):		
Permanent Resident Card #:		Type of Visa:

EMPLOYMENT INFORMATION		
Current employer:		
Employer Address (Street, City, State, Zip):		
Phone:	E-mail:	Fax:
Occupation With Specific Duties:		
Title:	Income:	Net Worth:
# Of Years Employed:		

OWNER INFORMATION (IF OWNER OF POLICY WILL BE OTHER THAN THE PROPOSED INSURED)		
Individual		
Name (First, Middle Last):		
Date of birth:	SSN:	Sex:
Address (Street, City, State, & Zip):		
Phone:	Email:	Relationship To Insured:
Business		
Entity Name:	Business Type (LLC, Partnership, Corporation):	
Address (Street, City, State, & Zip):		
Tax ID #:	Email:	Phone:
Trust		
Trustees:		
Trust Name:		
Trustor / Grantor:	Date:	

BENEFICIARY INFORMATION (IF BENEFICIARY IS DIFFERENT FROM THE OWNER OF THE POLICY)		
Name:		
Address (Street, City, State, & Zip):		
Phone:	Date Of Birth:	SSN #:

POLICY INFORMATION

IJU Agency Ltd.
1040 Avenue of the Americas, New York, New York 10018
Phone: 1(212)575-1860 Fax: 1(212)575-1897 Email: Info@IJUAgency.com

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Product Type (Whole Life, Universal Life, Whole Life):	
Face Amount:	Desired Premium Amount:
Payment Schedule (Monthly, Quarterly, Semi-Annual, Annual):	

RECENT APPLICATIONS, INFORCE COVERAGE, AND REPLACEMENT INFORMATION

Company Name	*Policy #*	*Date Issues*	*ADB Coverage*

LIFESTYLE HISTORY

	Yes	*No*	*If Yes, Please Explain:*
1) Have you been convicted of any moving vehicle violations in the past 2 years, or of Driving Under the Influence during the past 5 years, or have any convictions within the past 2 years caused your motor vehicle license to be suspended?			
2) Have you ever been convicted of a felony or misdemeanor?			
3) Have your been or are you currently involved in any bankruptcy proceedings that have not been charged? (If Yes, provide type and date discharge.)			
4) Do you participate in any type of racing, scuba diving, aerial sports, mountain climbing, Base or bungee jumping, or cave exploration?			
5) Do you participate in any aviation activity other than as a fare paying passenger?			
6) During the next 2 years do you intend to travel outside or reside outside of the USA for more than 2 weeks in a year?			
7) Are you receiving a cash incentive or other consideration (such as free insurance) as an inducement to apply for or become an insured under this life insurance policy?			
8) Do you have a plan in place with an unrelated third party, such as (but not limited to) a life settlement company or investor group, in regards to the sale or transfer of this policy?			

HEALTH HISTORY

	Yes	*No*	*If Yes, Please Explain:*
1) Are you taking any medications?			
2) Have you used any type of product containing tobacco or nicotine within the last 5 years?			
3) Within the past 5 years have you worked less than full time, received or applied for disability or worker's compensation?			

4) In the past 10 years have you been diagnosed, treated or taken medication for:

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A) Any disease or abnormal condition of the heart, circulatory system, high blood pressure, high cholesterol, irregular heartbeat, murmur, rheumatic fever, coronary artery disease, chest pain, angina, transient ischemic attack or stroke?			
B) Any disease of the lungs or respiratory system, sleep apnea, emphysema, asthma, bronchitis, tuberculosis, shortness of breath, allergies or disorder of the nose or throat?			
C) Any digestive system disease, including ulcer, chronic indigestion, liver, stomach, intestine or pancreas disorder, hepatitis, cirrhosis, jaundice, esophagus disorder, gallbladder disorder, or colon disorder?			
D) Any disorder of the nervous system, dizzy spells, epilepsy, convulsions, paralysis, unconsciousness, brain or eye disorders, or headaches?			
E) Any spine, hip, knee, shoulder, back, bones, muscles, arthritis, rheumatism, joints, skin, thyroid, gout or other gland disorder?			
F) Any urinary system disease including protein, sugar or blood in urine, kidney infection or stones, disorder or disease of the breast, prostate or bladder, or pelvic organs?			
G) Any depression, anxiety, bipolar, schizophrenia, attention deficit disorder (ADD), or any other developmental or psychological condition including memory loss, Alzheimer's, Dementia, or Post Traumatic Stress Disorder (PTSD)?			
H) Any anemia, hemophilia or disorders of the blood other than Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV)?			
I) Acquired Immune Deficiency Syndrome (AIDS) or (AIDS) related Complex (ARC)?			
J) Any cancer, polyp, other tumors?			
K) Diabetes or high blood pressure?			
5) Amputation due to disease or other medical condition?			
6) Ataxia, transverse Myelitis, Myasthenia Gravis, Autoimmune Disorder such as Lupus, Blindness, or Post Polio Syndrome?			
7) Parkinson's disease, Muscular Dystrophy, Huntington's Chorea, Motor Neuron Disease, Lou Gehrig's Disease (ALS), or Multiple Sclerosis?			
8) In the past 10 years have you used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, been advised by a physician to discontinue or reduce alcohol or drug intake, used drugs not prescribed by a physician?			
9)Within the past 5 years have you:			

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(Please fill out the information to the best of your ability.)

A) Consulted with a physician other than your personal physician or had x-rays, electrocardiograms, heart catheterization or other diagnostic tests, except for an HIV Test?			
B) Been admitted to a hospital, or been advised or plan to enter a hospital for observation, operation or treatment of any kind?			
10) Do you have any pending appointments with any medical professional?			
11) Has a parent or sibling been diagnosed or treated by a health professional for cancer, heart disease, Huntington's Disease or polycystic kidney disease?			
12) Do you currently:			
A) Use or require the use of any mechanical or medical devices such as: a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lift?			
B) Need help, assistance or supervision for, bathing, eating, dressing, toileting, walking, transferring, or maintaining continence?			
C) Need help, assistance or supervision in: taking medication, doing housework, laundry, shopping or meal preparation?			
13) Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: Falls, Paralysis, Numbness, Tremors, Imbalance, or any condition which causes limited motion?			
14) Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: memory loss, confusion, amnesia?			

FAMILY HISTORY

	Age If Alive	*Age At Death*	*Cause Of Death*
Father			
Mother			

DOCTOR & MEDICAL INFORMATION

Name Of Personal Physician (and all other medical specialists seen):	
Address (Street, City, State, & Zip):	
Date Last Seen:	Telephone:
Reason Consulted & Outcome:	

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<u>Notice</u>

This information is not an offer to sell insurance. Insurance coverage cannot be bound or changed via submission of this online form / application, e-mail, voice mail or facsimile. No binder, insurance policy, change, addition, and/or deletion to insurance coverage goes into effect unless and until confirmed directly with a licensed broker. Note any proposal of insurance we may present to you will be based upon the values developed and exposure to loss disclosed to us on this online form/application and/or in communications with us. All coverages are subject to the terms, conditions and exclusions of the actual policy issued. Not all policies or coverages are available in every state. You also agree to release us from any liability if this information is accidentally viewed by unauthorized persons. We will only use this information for insurance quoting purposes and not distribute to other parties.

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Prepared By: ______________________________ Signature: ______________________________ Date: _______________

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