Life Insurance: Fact Finder

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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

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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: ______________________

Type of Alcohol: ______________________ Frequency: ______________________

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

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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): ______________________________

____

____

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: ______________________________

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Name/specialty: ______________________ City, State: ______________________

Tel. #: ______________________ Date seen/reason: ______________________

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

____

____

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): ______________________

Relation: ______________________ Diagnosis: ______________________

Age at onset: ______________________ Age at death (if applicable): ______________________

Relation: ______________________ Diagnosis: ______________________

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): ______________________

____

____

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

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

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