



# Life Insurance Application Information

## PERSONAL INFORMATION

Legal name: \_\_\_\_\_  
First Middle Last Maiden name

Home Address: \_\_\_\_\_  
City State ZIP # of years

Place of Birth: \_\_\_\_\_ US Citizen? Yes  No  If you answered no, please indicate place of citizenship below.

Tobacco user: Yes  No  If you answered yes, what type? \_\_\_\_\_  
(i.e. cigarette, pipe, vape, etc.) Place of citizenship \_\_\_\_\_

How often? \_\_\_\_\_ Last use? \_\_\_\_\_

Date of birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Male  Female  Marital status: \_\_\_\_\_  
mm/dd/yy

Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email: \_\_\_\_\_

Driver's licence #: \_\_\_\_\_ State: \_\_\_\_\_ Exp. date: \_\_\_\_\_ SSN: \_\_\_\_\_  
mm/dd/yy

Employer: \_\_\_\_\_ Job title: \_\_\_\_\_ Years employed: \_\_\_\_\_ U.S. Armed Forces: Yes  No

Work address: \_\_\_\_\_  
City State ZIP

## FAMILY HISTORY

Mother: \_\_\_\_\_ Age: \_\_\_\_\_ Living? Yes  No  Cause of death: \_\_\_\_\_

Father: \_\_\_\_\_ Age: \_\_\_\_\_ Living? Yes  No  Cause of death: \_\_\_\_\_

Owner if other than insured: \_\_\_\_\_ SSN or Tax ID: \_\_\_\_\_ Date of birth or trust date: \_\_\_\_\_  
mm/dd/yy

Trustee: \_\_\_\_\_ Relationship to insured: \_\_\_\_\_

Address: \_\_\_\_\_  
City State ZIP

If trust owned, provide a copy of the first and signature page of trust.

## HOUSEHOLD FINANCIALS

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

Liabilities: \_\_\_\_\_

Liquid assets: \_\_\_\_\_

Earned income: \_\_\_\_\_

Unearned income: \_\_\_\_\_

Household income: \_\_\_\_\_

Source of funds: \_\_\_\_\_

Net worth: \_\_\_\_\_

## MEDICAL HISTORY

Have you visited a doctor in the last 5 years? Yes  No  If your answer is **yes**, fill lines below:

Notes (optional):

Doctor name: \_\_\_\_\_ Date of last visit: \_\_\_\_\_  
mm/dd/yy

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

Reason for visit: \_\_\_\_\_

Beneficiary name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
mm/dd/yy

Beneficiary address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Beneficiary SSN: \_\_\_\_\_

Any booked travel planned outside USA? Yes  No  If so: Business  Pleasure  Travel dates: \_\_\_\_\_  
mm/dd/yy

Travel duration: \_\_\_\_\_ Destination: \_\_\_\_\_ City \_\_\_\_\_ Country \_\_\_\_\_

Advisor / Agent Name: \_\_\_\_\_ Years known client: \_\_\_\_\_ Advisor / Agent SSN: \_\_\_\_\_

Any other life insurance or annuity in force? Yes  No  If so, Replacement: Yes  No  1035 Exchange: Yes  No

Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Death benefit: \_\_\_\_\_ Date issued: \_\_\_\_\_ Current premium: \_\_\_\_\_  
mm/dd/yy

Do we have informal: Yes  No  Back dating: Yes  No  Do we have an exam from another company: Yes  No

Was an Illustration being used in this sale? Yes  No  IF YES, Please attach the Illustration with the submitted application.

## EXISTING LIFE INSURANCE POLICIES

Death benefit:

Carrier:

Product type:

Planned premium and duration:

Existing cash value:

Surrender value:

Living benefits:

Owner/insured:

Death benefit:

Carrier:

Product type:

Planned premium and duration:

Existing cash value:

Surrender value:

Living benefits:

Owner/insured:

Death benefit:

Carrier:

Product type:

Planned premium and duration:

Existing cash value:

Surrender value:

Living benefits:

Owner/insured: