LIFE INSURANCE QUESTIONNAIRE

Complete the information below and send back via email, mail, drop off at office, or night drop box for a quote.

APPLICANT COVERAGE

Select the amount of Term Coverage (check one)

☐ $100,000 ☐ $75,000

☐ $50,00 0 ☐ $25,000

If no amount is selected, the lowest amount is assumed.

Applicant Information

First_____ MIDDLE_____

LAST_____

SSN_____-_____-_____ SEX _____ DOB_____

Primary Ph ( )_____

e-mail address _____

Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities?

☐ No

☐ Yes - company name and policy number_____

_____

SPOUSE OR PARTNER COVERAGE (if applying)

Select the amount of Term Coverage (check one)

☐ $100,000 ☐ $75,000

☐ $50,000 ☐ $25,000

If no amount is selected, the lowest amount is assumed.

Spouse OR Partner Information

First_____ MIDDLE_____

LAST_____

SSN_____-_____-_____ SEX _____ DOB_____

Primary Ph ( )_____

e-mail address _____

Will the coverage applied for replace, discontinue, or change any existing life coverage or annuities?

☐ No

☐ Yes - company name and policy number_____

_____

HEALTH INFORMATION

Please answer these questions (spouse/partner only if applying)

	APPLICANT	SPOUSE / PARTNER
1. *Are you unable to* work or perform normal activities due to a chronic illness or permanent injury?	[ ] No [ ] Yes	[ ] No [ ] Yes
2. Have you, within the past 5 years, been treated for or diagnosed by a Medical professional with the following	[ ] No [ ] Yes	[ ] No [ ] Yes

If **YES to Question 2, check all that apply.**

	APPLICANT	SPOUSE/PARTNER
HIV, AIDS or AIDS-Related Complex	☐	☐
Cancer (except basal cell)	☐	☐
Heart Disease/Condition (except high blood pressure)	☐	☐
Diabetes Requiring Insulin	☐	☐
Stroke	☐	☐
Chronic Disorder of the Brain or Spinal Nerve	☐	☐

	APPLICANT	SPOUSE/PARTNER
Alcohol or Drug Abuse	☐	☐
Chronic Liver Disease	☐	☐
Chronic Kidney Disease	☐	☐
Chronic Depression	☐	☐
Mental Disorder	☐	☐
Chronic Lung Condition	☐	☐

Additional Comments for agent: _____

_____