

CONFIDENTIAL WORKSHEET FOR LIFE AND HEALTH INSURANCE

PERSONAL:

Your full name: _____ Maiden name (if applies): _____
Birthdate: _____ Birthplace: _____
Social Security #: _____ Driver's license #: _____ (State) _____
Date of expiration: _____
Marital status: _____ Name of spouse: _____
Spouse's birthdate: _____ Spouse's Social Security #: _____
Names of children: _____

DOB _____
DOB _____
DOB _____

Have you ever had your driver's license suspended, ever been arrested, or had two or more moving violations in the past five years? _____ If yes, explain: _____

Do you plan to travel extensively outside the United States? _____ If yes, explain: _____

Are you in the military reserves? _____ If yes, explain: _____

Do you fly a plane or have hazardous hobbies? _____ If yes, explain: _____

HOME

ADDRESS: _____

Country: _____ # Years: _____ Telephone #: _____

If less than 5 years, your prior address: _____

FINANCIAL INFORMATION:

Your gross earnings (before taxes): _____

Last year's pension plan contribution/Bonus: _____

Total assets (i.e. house, retirement fund): _____

Total liabilities (i.e. mortgage, loans): _____

Approximate net worth: _____ Have you ever filed for bankruptcy? _____

Amount unearned income (if over \$1,000/year from sources such as rent, dividends or interest): _____

BUSINESS:

Your employer: _____ Date of hire: _____

Address: _____

Company tel. #: _____ Fax #: _____ # Hours worked/week: _____

Your job title: _____

Using a typical work week, please describe your occupational duties by indicating the approximate % of time devoted to the following duties: _____ % Sales _____ % Travel _____ % Managerial/Admin

_____ % Physical/Manual _____ % Other *If Other, please provide details:* _____

How long have you worked in your current occupation? _____

In the last 30 days, have you worked less than your normal work week because of sickness or injury? If yes, explain: _____

If employed here less than 3 years, your prior employer was: _____

Do you have a second job? _____ If yes, where? _____

Doing what? _____ With an annual income of: _____

Employee Benefits – Do you have:

Group life insurance? _____ Amount? _____

Group disability insurance? _____ Amount? _____

POLICY OWNER (Circle and complete where appropriate.)

Insured _____ Spouse _____

Corporation _____ Trust* _____

Other (specify) _____ IRS Identification # 04- _____

*Legal Name: _____ Social Security # _____

Primary beneficiary: _____ Relationship to insured: _____

Second beneficiary: _____ Relationship to insured: _____

MEDICAL HISTORY: Height: _____ Weight: _____ lbs. Any change in the last year? _____

Name, address, and phone number of your personal physician: _____

Date of last visit? _____ Reason: _____

Result(s): _____

Have you ever used any tobacco products?	Yes []	No []
If yes, what? _____ Quantity: _____ Date last used? _____		
Have you ever consumed alcoholic beverages?	[]	[]
If yes, How often? _____ How much (ounces)? _____		
Have you ever received treatment for, or joined an organization because of, alcohol or drug use?	[]	[]
Were you ever rejected or deferred from military service?	[]	[]
Have you ever requested or received benefits because of injury or sickness?	[]	[]
Has any insurance company ever rated or rejected you?	[]	[]
Are you now taking any medication or are under a doctor's care?	[]	[]
(List medications:)		
Have you had an EKG, X-ray, or any diagnostic test?	[]	[]
Do you have, or have ever been treated for, disorders of:		
Eyes, ears, nose, or throat?	[]	[]
Cardiovascular or circulatory system, including blood disorders?	[]	[]
Stomach or intestines?	[]	[]
Genito-urinary, or pancreatic disorders?	[]	[]
Any mental or nervous disorders?	[]	[]
Respiratory system, such as asthma, shortness of breath, coughing?	[]	[]
Bones, joints, or muscles, including any back disorders?	[]	[]
Glands, cysts, or cancer?	[]	[]
Have you received treatment for or been diagnosed as having AIDS or ARC?	[]	[]
Have you had surgery, or been advised to have surgery that was not completed?	[]	[]
Do you have any appointment scheduled, or have you seen a doctor within 5 years?	[]	[]
Have you ever attempted suicide? Have you ever been treated for depression, stress, anxiety, or any other psychological or emotional disorder or symptoms?	[]	[]
Do you exercise regularly? [] Daily [] Weekly [] Other _____	[]	[]
Are you now pregnant? What is the expected date of delivery? _____	[]	[]
Do you have any family history of tuberculosis, diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, or suicide?	[]	[]

Please detail your "YES" answers below, giving condition treated, dates and duration, current status of condition, and names and addresses of all doctors and hospitals involved. (Continue on a separate sheet if necessary.)

FAMILY HISTORY:

	Age if living	Condition of health	Age at death	Cause of death
Father				
Mother				
Brother(s)				
Sister(s)				

INSURANCE DATA: Are other life or health insurance applications pending? _____
 Are notices to be sent to your home, office, or other (please specify)? _____
 Billing will be annual unless otherwise requested. Other request? _____

Life Insurance in force:

Company name	Amount	Type	Year purchased	AD&D amount	WP

Personal disability insurance in force:

Company name	Amount	Waiting period	Benefit period	Riders	Year purchased

DATE PREPARED: _____ COMPLETED BY: _____ If a personal interview is needed in connection with this application, contact me between _____ and _____ at _____