

Client Data

NAME: _____ COMPANY NAME: _____

DATE OF BIRTH: _____ CITIZENSHIP: _____

MARRIED, SINGLE, WIDOWED, DIVORCED, SEPARATED? _____

SOCIAL SECURITY NUMBER: _____ HEIGHT _____ WEIGHT _____

DRIVER'S LICENSE NUMBER: _____ STATE: _____

DRIVER'S LICENSE EXPIRATION DATE: _____ BIRTHPLACE: _____

ADDRESS – RESIDENCE: _____ ADDRESS – BUSINESS: _____

_____ ZIP _____ ZIP _____

COUNTY: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

EMAIL ADDRESS: _____

PREFERRED METHOD OF CONTACT (PLEASE CHECK ALL THAT APPLY):

HOME PHONE _____ CELL PHONE _____ EMAIL _____

EMPLOYED OR RETIRED: _____

IF EMPLOYED, NAME OF EMPLOYER: _____

PRIMARY OCCUPATION: _____ DATE OF HIRE: _____

ANNUAL INCOME FROM OCCUPATION: _____

OTHER INCOME: _____ SOURCE OF OTHER INCOME: _____

NET WORTH: _____ REFERRED BY: _____

ATTORNEY: _____ ACCOUNTANT: _____

MEDICAL QUESTIONS:

DO YOU SMOKE NOW? _____ IF ANSWER IS NO, DID YOU EVER

SMOKE CIGARETTES? _____, PIPES? _____, CIGARS? _____ IF ANSWER

TO ANY OF THE ABOVE IS YES, HOW LONG AGO DID YOU STOP? _____

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING: CANCER _____,

CARDIO/PULMONARY _____, DIABETES _____. IF ANSWER TO ANY OF THE ABOVE IS YES, PLEASE LIST DETAILS,

STATUS AND TREATMENT: _____

Client Data cont'd.

NAMES, PHONE NUMBERS, AND ADDRESSES OF ANY DOCTORS YOU SEE OR HAVE SEEN WITHIN THE PAST 5 YEARS FOR ANY MEDICAL PROBLEMS:

| | |
|----------|----------|
| 1. _____ | 2. _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| 3. _____ | 4. _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| 5. _____ | 6. _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

EXISTING LIFE INSURANCE:

| INSURANCE COMPANY | POLICY NO. | DEATH BENEFIT |
|-------------------|------------|---------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

FOR REPRESENTATIVE USE ONLY:

ORDER EXAM AT SAME TIME AS MEDICAL RECORDS OR AFTER OFFERS ARE RECEIVED? _____ ANTICIPATED FACE AMOUNT _____

STATE OF APPLICATION _____ STATES WHERE CLIENT HAS RESIDENCES _____

ANTICIPATED PREMIUM: _____ ANTICIPATED CARRIER (IF KNOWN) _____

PLAN TYPE: (please check all that apply)

412(i) _____ 419(e) _____ PENSION RESCUE _____ FINANCE _____

LIFE INS. IN A QUALIFIED PLAN _____ OTHER (explain) _____