Today's Date:_____

INFORMATION SHEET

First Name:		Middle Name:		Last Name:	
DOB:	Age:	(M) (F)	SSN:	Is this a Replacement: (Y) (N)	
Height:	Weight:	Driver License # or ID #:	Exp Date:	Type of Visa: Resident Alien, Green Card, Permanent Resident, Work Visa, Other, N/A	
U.S. Citizen: (Y) (N)	How Long in the Country:		Visa #:		Visa Expiration Date:
Home Address: Street			Phone Number:		Place of Birth:
			Smoker / Non-Smoker	Status: Single, Married, Divorced, Separated, Widow	
City State ZIP CODE			How Long at Address:	Email:	

EMPLOYMENT INFORMATION

Employer Name:				Phone Number:
Employer Address: City: State: Zip Code:				How Long:
Type of Business:	Position:	Annual Income:		Net Worth:

DOCTOR'S INFORMATION

Primary Doctor Name:				Phone Number:
Doctor Address: City : State: Zip Code:				
Any Medical Condition:	Medication:	Date Last Visit:	Result:	Kaiser Patient: (Y) / (N)

CRIMINAL BACKGROUND

Any Felonies, Misdemeanors, DUI'S or License Suspensions Ever : (Yes) or (No) If Yes, please explain in detail and provide date.

BENEFICIARIES If more, please write on the back of this sheet with available information. Thank you.

Full Name: First / Middle/ Last	%	Relationship:	DOB:	Primary	
Address:			SSN:		Phone Number:
Full Name: First / Middle/ Last	%	Relationship:	DOB:	Primary or Secondary	
Address:			SSN:		Phone Number:
Full Name: First / Middle/ Last	%	Relationship:	DOB:	Primary or Secondary	
Address:			SSN:		Phone Number:

BANK INFORMATION

Bank Name:	Routing #:	Date of Draft: 1st - 28th
Name on the Account:	Account #:	

Insured's Signature : _____ Policyowner's Signature : _____
If other than Insured

Policy Number:		Issued Date:	Medical Exam Date:	Exam Scheduled by:	Barcode:	
Term	Super or LB: 10 15 20 25 30YRS		Amount of Coverage:	Contribution:	LEVEL OR INCREASING	Trial Application or Cash w/Application
Permanent	Provider Chosen:	Product Type:	Amount of Coverage:	Contribution:		
Writing Agent Name & Code # :			Split Agent Name & Code # :		Rating: Preferred Elite, Preferred Plus, Preferred, Standard	
Main Purpose of the Plan:			City and State Signed by Applicant:			
1035 Exchange Amount:		Company Name & Policy #:		Issued Date:	Death Benefit:	
Special Instructions:						

Field Underwriting

REQUIREMENTS:

- ☐ **Copy of ID / Driver License**
- ☐ **Copy of Greencard**
- ☐ **Copy of ITIN / SSN**
- ☐ **Copy of Passport**
- ☐ **Copy Consular Card**

Proposed Insured Full Name: _____

Date of Birth: _____

Height: _____ **Weight:** _____

1) **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?**
   HAVE YOU EVER USED OR EXPERIMENTED WITH MARIJUANA?

   _____

   _____

2) **HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH OR TREATED FOR MAJOR MEDICAL ISSUE(S):**
   If yes, please explain.

   _____

   _____

3) **HAVE YOU EVER HAD OR BEEN DIAGNOSED WITH OR TREATED FOR MINOR MEDICAL ISSUE(S):**
   If yes, please explain.

   _____

   _____

4) **DO YOU TAKE ANY MEDICATIONS REGULARLY, INCLUDING OVER-THE-COUNTER MEDICATIONS.**

   If yes, give the name of the medication(s), dose & frequency.

   _____

   _____

5) **DO YOU DRINK ALCOHOLIC BEVERAGES? If yes, provide type, frequency & amount.**
   DO YOU TAKE PROTEIN SUPPLEMENTS? If yes, provide type, frequency & amount.

   _____

   _____

6) **ANY FELONIES, MISDEMEANORS, DUI(s) or LICENSE SUSPENSION EVER? If yes, please explain.**

   _____

   _____

7) **DO YOU PLAN TO TRAVEL OUTSIDE OF THE UNITED STATES WITHIN THE NEXT YEAR? If yes, where?**

   _____

   _____

ISSUES SUCH AS: *STROKE, HIGH BLOOD PRESSURE, HEART ATTACK, DIABETES, THYROID, SLEEP APNEA, HEART ISSUE, ANXIETY, DEPRESSION, SURGERY, ETC.*

_____ _____
Agent Signature Date

_____ _____
Agent Name (Print Name) Agent Code