Comprehensive Medical Questionnaire

CONSIDERATIONS

Minimum Term Face amount is $2,500,000

Minimum Permanent Face amount is $1,000,000

Minimum Anticipated Premium is $5,000 - $10,000+

APPLICANT INFORMATION

Full Name: ____

Date of Birth:____________________ SSN:______________________________ Male Female

Home Address: ____

City, State, Zip: ____

Preferred Phone Number: ____________________________

PLAN OF INSURANCE REQUESTED

Individual: Term UL IUL VUL WL Survivorship: SUL SVUL

New Coverage Amount Requested: $ ________________________

In-Force Life Coverage Amount: $ _______________________

NICOTINE USE

Please note any tobacco use within the last five years

None

Cigarettes How much and how often? ________________________

Cigars How much and how often? ________________________

Chewing Tobacco How much and how often? ________________________

Nicotine Gum/Patch How much and how often? ________________________

Other: __________________ How much and how often? ________________________

If you have used any of the above products, when did you stop?

____

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HEALTH CONDITIONS

Please list any health conditions that you currently seek medical treatment for, including as much detail as possible regarding the date of diagnosis and treatment.

For example: high blood pressure, sleep apnea, diabetes, etc.

____

Approximate Height: _______ Approximate Weight: _________

Personal Physician Name:____

Physician City & State: ____

Physician Phone Number: ____

Last Visit Date: __________________ Reason for Visit: _______________________________

____

____

Other Medical Specialists? Please list all:

____

____

FAMILY MEDICAL HISTORY

Do you have any family history (parent or sibling) of cardiovascular disease, cerebrovascular disease, diabetes or cancer prior to age 60? Yes No

If yes, provide full details with impairment, age at onset and age at death if deceased:

Father: ____

Mother: ____

Siblings: ____

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