Life

Client appointment form

Be prepared!

Use this form to ensure you have all the information you need for a smooth life insurance application process.

Proposed Insured

Legal name: _____

Ever used a different name? ☐ Y **or** ☐ N If Yes, what name(s)? _____

Date of birth:_____ Age last: _____ Backdate to save age? ☐ Y **or** ☐ N Gender: ☐ Male **or** ☐ Female

Marital status: _____ SSN:_____ State and country of birth: _____

Employer: _____ Occupation: _____

Employer Address: _____

Annual income: _____ Net worth: _____

Does the proposed insured have a valid driver's license or ID? ☐ Y **or** ☐ N

Driver's license number: _____ Issue state: _____

If no driver's license, other valid form of identification: _____ Issue state or country: _____

Residential address: _____

Residence change in the last 3 months? ☐ Y **or** ☐ N

If yes, list previous address: _____

Mailing address *(if different than above)*: _____

Best phone number to contact: _____ Best time to contact: _____

Other phone number: _____ Email: _____

In the past 12 months, has the Proposed Insured completed a paramedical with lab work with any life insurance application, including this one? ☐ Y **or** ☐ N

For insureds under age 18

Last doctor visit: _____ Doctor's name: _____

Reason for visit and results: _____

Owner

Maximum of 2 owners with ExactApp®

Will the proposed insured be the owner? ☐ Y **or** ☐ N

Will the policy be delivered electronically? ☐ Y **or** ☐ N

Is the owner of this policy an Active Duty Service Member of the United States Armed Forces? ☐ Y **or** ☐ N

Is the owner of this policy subject to IRS withholding? ☐ Y **or** ☐ N

Is there a joint or contingent owner? ☐ Y **or** ☐ N *List joint or contingent owner information on a separate page.*

Owner legal name: _____

Address: _____

Date of birth: _____ SSN: _____ Driver's License Number: _____

Beneficiaries

Maximum of 5 with ExactApp - Percentage split must be 100%. List additional beneficiaries on a separate page.

Primary beneficiary legal name: _____ % split: _____

Date of birth: _____ SSN: _____ Relationship: _____

Address: _____

Phone number: _____ Email: _____

Contingent beneficiary legal name: _____ % split: _____

Date of birth: _____ SSN: _____ Relationship: _____

Address: _____

Phone number: _____ Email: _____

FOR AGENT USE ONLY. NOT TO BE USED FOR CONSUMER SOLICITATION.

Plan information:

Product type: ☐ Term ☐ UL ☐ IUL Product: _____

Rate class: ☐ Tobacco **or** ☐ Non-tobacco

Has the insured used cigars in the past 12 months? ☐ None ☐ Up to 1 per month ☐ Up to 2 per month ☐ 2+ per month

Has the insured used nicotine in the past 12 months? ☐ Y **or** ☐ N

Death benefit amount: _____ Death benefit option: ☐ level ☐ increasing ☐ ROP

Life insurance test: ☐ GPT **or** ☐ CVAT

Riders: _____

Would the Proposed Insured like to apply for additional coverage? ☐ Y **or** ☐ N

If yes, details: _____

Existing insurance / Replacement information:

- Does the proposed insured have any life insurance or annuities currently in force or pending? ☐ Y **or** ☐ N
- Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ Y **or** ☐ N
- Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy? ☐ Y **or** ☐ N

Company name	Coverage amount	Policy number	Year issued	Replacing?
				☐ Y **or** ☐ N
				☐ Y **or** ☐ N
				☐ Y **or** ☐ N

Temporary Insurance Agreement (TIA)

Would the proposed insured like a Temporary Insurance Agreement (TIA)? ☐ Y **or** ☐ N

*If **yes**, please answer the following:*

- Any major medical conditions in the past 5 years? ☐ Y **or** ☐ N
- In the past 12 months, unintentionally lost more than 10 pounds? ☐ Y **or** ☐ N
- In the past 90 days, been admitted or advised by a medical professional to be admitted to a hospital or other licensed health care facility (other than a normal childbirth), or been advised by a medical professional to have a surgery or diagnostic test or procedure (other than a test related to the HIV virus) which has not been completed or results are unknown? ☐ Y **or** ☐ N
- Life insurance that was declined, postponed, or charged an additional premium in the past five years? ☐ Y **or** ☐ N
- Is the proposed insured under 15 days of age or over 70 years of age? ☐ Y **or** ☐ N

Payor

Policy payor name: _____ Phone: _____

Mode of payment: ☐ Check **or** ☐ EFT **or** ☐ Other: _____

Modal premium amount: _____

If setting up EFT answer the following:

EFT frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Bank name: _____ Bank account type: ☐ Checking **or** ☐ Savings

Bank routing number: _____ Bank account number: _____

Personal history

- Is the proposed insured fluent in English? ☐ Y **or** ☐ N
- Is there any other reason, such as visual impairment or technical limitation, that would prevent the proposed insured from completing the part 2 application online? ☐ Y **or** ☐ N

Documents containing customers' personal information should be maintained securely in a manner consistent with the Compliance Manual as well as applicable state and federal privacy requirements. Annuities and life insurance are issued by, and product guarantees are solely the responsibility of, Life Insurance Company.

CA Chronic and Critical Illness

Is the person to be insured under this Endorsement covered by an individual, group health insurance policy or an HMO or employer plan providing for essential benefits?

☐ Yes ☐ No

Are the Accelerated Death Benefits for Chronic Illness being applied for intended to replace any long term care insurance presently in force?

☐ Yes ☐ No

Has a licensed medical professional ever treated the Proposed Insured for or diagnosed the Proposed Insured with:

Amyotrophic lateral sclerosis (ALS, Lou Gehrig's Disease)?

☐ Yes ☐ No

Huntington's chorea?

☐ Yes ☐ No

Ataxia?

☐ Yes ☐ No

Transverse myelitis?

☐ Yes ☐ No

Myasthenia gravis?

☐ Yes ☐ No

Senility?

☐ Yes ☐ No

Chronic, recurrent or persistent memory loss or confusion?

☐ Yes ☐ No

Cognitive impairment?

☐ Yes ☐ No

Dementia?

☐ Yes ☐ No

Organic brain disease?

☐ Yes ☐ No

Amputation of more than one limb?

☐ Yes ☐ No

A stroke?

☐ Yes ☐ No

More than one mini stroke (transient ischemic attack, TIA)?

☐ Yes ☐ No

Osteoporosis with compression fracture(s) or other related fracture(s)?

☐ Yes ☐ No

Post polio syndrome?

☐ Yes ☐ No

Chronic pain syndrome currently requiring treatment with narcotic medication(s)?

☐ Yes ☐ No

Within the past 2 years, has the Proposed Insured:

Been advised by a licensed medical professional to permanently discontinue the driving of an automobile?

☐ Yes ☐ No

Required care from a licensed medical professional for a fall?

☐ Yes ☐ No

Does the Proposed Insured currently: Reside in a long term care facility or nursing home?

☐ Yes ☐ No

Receive or require the services of a home health care provider?

☐ Yes ☐ No

Attend adult day care?

☐ Yes ☐ No

Receive, or applied to receive, any type of disability benefits, excluding maternity benefits?

☐ Yes ☐ No

Use or require the use of: Devices such as a wheelchair, motorized scooter, walker, quad cane or stair lift?

☐ Yes ☐ No

Oxygen or a respirator?

☐ Yes ☐ No

A catheter?

☐ Yes ☐ No

A dialysis machine?

☐ Yes ☐ No

Need, or been advised by a licensed medical professional to receive help or supervision of another to:

Perform personal care?

☐ Yes ☐ No

Perform household chores?

☐ Yes ☐ No

Get in and out of a bed or chair?

☐ Yes ☐ No

Have, or applied for, a handicap placard or handicap license plate?

☐ Yes ☐ No

The information collected on this form will only be used to complete a Life Insurance application and will not be shared without the applicant's permission.

INDIVIDUAL LIFE APPLICATION PART 2

PROPOSED INSURED PERSONAL INFORMATION

1. Are you a U.S. Citizen or do you have a permanent Visa? ☐ Yes ☐ No
2. Have you ever used a different name? ☐ Yes ☐ No If yes, give name used and time period. _____

TO BE COMPLETED FOR MILITARY PERSONNEL (Including National Guard and Reserves)

3. Job Duties

4. Are you currently drawing extra duty or hazard pay? ☐ Yes ☐ No

5. Military Information ☐ USA ☐ USN ☐ USAF ☐ USMC ☐ USCG ☐ Other (Specify) _____
   Military ID _____
   Pay Grade: Rotation Date: Expected Discharge Date:

6. Has the Proposed Insured applied to be a member of, or been a member of, a special forces or special or hazardous duty organization? ☐ Yes ☐ No
   If Yes, provide specific details.

7. Has the Proposed Insured been alerted to, volunteered for, or received formal orders to a hazardous area or overseas assignment? ☐ Yes ☐ No
   If Yes, provide specific details.

UNDERWRITING AND LIFESTYLE INFORMATION

8. Has the Proposed Insured ever used cigarettes, nicotine patches, nicotine gum, or other nicotine substitutes? ☐ Yes ☐ No
   If yes, what product? ☐ Cigarettes ☐ Nicotine patches ☐ Nicotine gum ☐ Other: _____
   If yes, was use of the product within: ☐ last 12 months ☐ last 24 months ☐ last 36 months ☐ last 60 months ☐ 60+ months

9. Has the Proposed Insured used tobacco in pipe or cigar form in the last 12 months? ☐ Yes ☐ No
   If yes, how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

Please provide Details to "Yes" answers for Q 10. through 15. and "No" answer to Q 16. in the Details Section on the following page.

10. In the past 10 years, has the Proposed Insured:
    a. Used barbiturates, hallucinatory drugs, narcotics, including crack, ecstasy, opium derivatives, marijuana, LSD, PCP, or any derivatives of these drugs not prescribed by a licensed medical practitioner? ..... ☐ Yes ☐ No
    b. Been advised by a licensed medical professional to get medical treatment or undergone any medical treatment, counseling or hospitalization for drug abuse? ..... ☐ Yes ☐ No
    c. Been advised by a licensed medical professional to limit your alcohol use or been advised to get medical treatment or undergone any medical treatment, counseling or hospitalization for alcoholism, excessive alcohol use or abuse? Or, have you subsequently consumed alcohol after receiving counseling or medical treatment for alcohol use? Or, do you drink on average more than three alcoholic drinks per day? ..... ☐ Yes ☐ No
    d. Plead guilty to or been convicted of a felony or misdemeanor? If yes, provide details on the nature of the plea or conviction, the date and state where the plea or conviction occurred, and whether time was served in prison. ..... ☐ Yes ☐ No
    e. Been refused life insurance or charged an extra premium for life insurance? ..... ☐ Yes ☐ No

11. Has the Proposed Insured:

a. Within the past five years, had his/her driver's license revoked or suspended or been convicted of reckless driving, driving without a valid license, or for driving while under the influence of alcohol and/or drugs (DWI, DUI)? ☐ Yes ☐ No

b. Within the past five years, plead guilty or been convicted of any speeding or motor vehicle moving violation, been involved in any accident in which he/she was found to be at fault, or plead guilty or been convicted for driving under the influence of alcohol and/or drugs? ☐ Yes ☐ No

c. Flown a plane in the past 24 months or plan to fly in the next 12 months as a pilot, copilot, student pilot, military pilot, engineer or in any other capacity except as a regularly scheduled commercial airline pilot or fare-paying passenger? ☐ Yes ☐ No

d. In the past 12 months or in the next 12 months, engaged in, or plan to engage in, the following recreational activities : hang gliding, skydiving, motor vehicle/cycle racing, rock climbing, ballooning, bungee jumping, mountain climbing, motor boat racing, snowmobile racing, ultra light aircraft flying, scuba diving to more than 50 feet in depth, or in caves, ship wrecks or deep seas? ☐ Yes ☐ No

e. Traveled to or resided for more than 30 days outside of the U.S., U.S. territories, Canada, or Japan within the past 12 months or plan to travel to or reside outside of the U.S., U.S. territories, Canada, or Japan in the next 12 months? ☐ Yes ☐ No

f. Filed for bankruptcy that is pending or expect to file bankruptcy in the next 12 months? ☐ Yes ☐ No

12. Has, or will, the Proposed Insured or Owner of this policy been, or be, compensated in any way to purchase this policy? ☐ Yes ☐ No

13. Will the proceeds of a home equity loan or reverse mortgage transaction be used to pay the premiums on this policy? ☐ Yes ☐ No

14. Has the Proposed Insured or Owner of this policy financed, or intend to finance, all or a portion of the premiums for this policy? ☐ Yes ☐ No

15. Has the Proposed Insured, Owner, or Beneficiary entered into or are they considering entering into any other agreement with a third party, trust, or other entity, in regard to this policy, including, but not limited to, an agreement to sell, transfer or assign the policy or any policy rights or beneficial interests? ☐ Yes ☐ No

16. Is the Proposed Insured or Owner of this policy paying for this policy with his/her own funds? ☐ Yes ☐ No

DETAIL SECTION FOR 'YES' ANSWERS FOR QUESTIONS 10. THROUGH 15. AND "NO" ANSWER TO QUESTION 16. If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Details

17. Who is your primary physician or health care provider? If None, check here ☐

Physician or Health Care Provider Name/Address/Telephone	Date Last Consulted	Reason Seen and Results of Visit (include diagnosis, treatment given, medication prescribed)

18a. What is your current height and weight? _____ FT. _____ IN. _____ LBS

18b. Have you gained or lost more than 15 pounds in the last year? ☐ Yes ☐ No

Please provide Details to "Yes" answers for Questions 19. through 22. in Details section following these questions.

19. In the past 10 years, has the Proposed Insured been diagnosed by a licensed medical professional, treated or recommended to get treatment from a licensed medical professional, hospitalized, or presently taking prescription(s) or medication(s) or had any medical procedures for any of the following:

a. Angina, chest pain, heart attack, heart failure, heart surgery, arrhythmia heartbeat, abnormal EKG, coronary artery bypass, angioplasty, stents, peripheral vascular disease, circulatory disorder, valvular heart disease, cardiomyopathy or heart murmur? ☐ Yes ☐ No

b. High blood pressure, hypertension or abnormal cholesterol levels? ☐ Yes ☐ No

c. Stroke, seizures, epilepsy, dizziness, fainting, or dementia? ☐ Yes ☐ No

d. Multiple Sclerosis, neuritis, neuropathy, paralysis, muscular dystrophy, Parkinson's disease or any other disorder of the muscles? ☐ Yes ☐ No

e. Arthritis, chronic pain, fibromyalgia, connective tissue disease, lupus or scleroderma? ☐ Yes ☐ No

f. Cancer, malignancy, tumor, melanoma, lymphoma, Hodgkin's disease or leukemia? ☐ Yes ☐ No

g. Chronic obstructive pulmonary or lung disease, chronic bronchitis, emphysema, sarcoidosis, asthma, shortness of breath, tuberculosis or sleep apnea? ☐ Yes ☐ No

h. Diabetes, pre-diabetes or impaired glucose tolerance, sugar in the urine, disease or disorders of the adrenal, parathyroid, pituitary or thyroid glands? ☐ Yes ☐ No

i. Disorder of the kidney, bladder or urinary system, abnormal PSA, abnormal pap smear without subsequent normal pap smear or protein or blood in the urine? ☐ Yes ☐ No

j. Anemia, hemophilia, or clotting disorder, excluding HIV (Human Immunodeficiency syndrome)? ☐ Yes ☐ No

k. AIDS (Acquired Immune Deficiency Syndrome), any other disease or disorder of the immune system, or positive HIV (Human Immunodeficiency syndrome) test in connection with an application for insurance? ☐ Yes ☐ No

l. Colitis, ulcerative colitis, Crohn's, esophageal varices, peptic or gastric ulcer, intestinal or rectal bleeding, diverticulitis, colon polyps, cirrhosis, hepatitis, or liver failure? ☐ Yes ☐ No

20. Other than indicated above, in the past 12 months, has a licensed medical professional recommended the Proposed Insured to:

a. Have a check up, EKG, X-ray, blood or urine test or any other diagnostic test that has not been performed, or get medical advice or treatment for any reason (excluding HIV testing unless such test was in connection for an application for insurance)? ☐ Yes ☐ No

b. Be admitted to a hospital, medical facility, nursing home or assisted living facility? ☐ Yes ☐ No

21. Is the Proposed Insured currently taking any prescription medications, herbal remedies or non-prescription medications for any condition, disease or disorder not listed above? ☐ Yes ☐ No
If yes, list the medications and remedies and the reasons for which they are taken.

22. Is the Proposed Insured currently receiving or have an application pending for any illness or disability benefits or compensation? ☐ Yes ☐ No

DETAILS SECTION FOR 'YES' ANSWERS FOR QUESTIONS 19. THROUGH 21. If more space is needed, attach additional sheet, identify question(s), sign and date.

Question #	Date, Diagnosis, Treatment, Results and Duration	Name, Address and Phone # of Attending Physician & Hospital

23. If not previously listed, please provide full name, address and phone numbers of personal physician(s) and any other physician(s) consulted in the past five years below. If more space is needed, attach additional sheet, identify question, sign and date.

Name, Address and Phone # of Attending Physician	Date and Findings of Last Visit	Tests performed and treatment received

24. Do you have medical records under any other name? ☐ Yes ☐ No

If yes, provide details: _____

FAMILY HISTORY

25. Does the Proposed Insured have or did have a parent or brother or sister who, before age 60, was diagnosed with or died from cardiovascular disease, cancer (except basal or squamous cell cancer of the skin), Huntington's Chorea, familial polyposis, or polycystic kidney disease? ☐ Yes ☐ No

If yes, provide details in Family Health Chart below, including age at onset, if still living.

Family Health Chart

Relationship to Proposed Insured	Condition or Cause of Death	Current Age	Age at Onset	Age at Death