Name ____________________________ DOB_____________ Age_____ Height________ Weight________

Name ____________________________ DOB_____________ Age_____ Height________ Weight________

Name ____________________________ DOB_____________ Age_____ Height________ Weight________

Name ____________________________ DOB_____________ Age_____ Height________ Weight________

Name ____________________________ DOB_____________ Age_____ Height________ Weight________

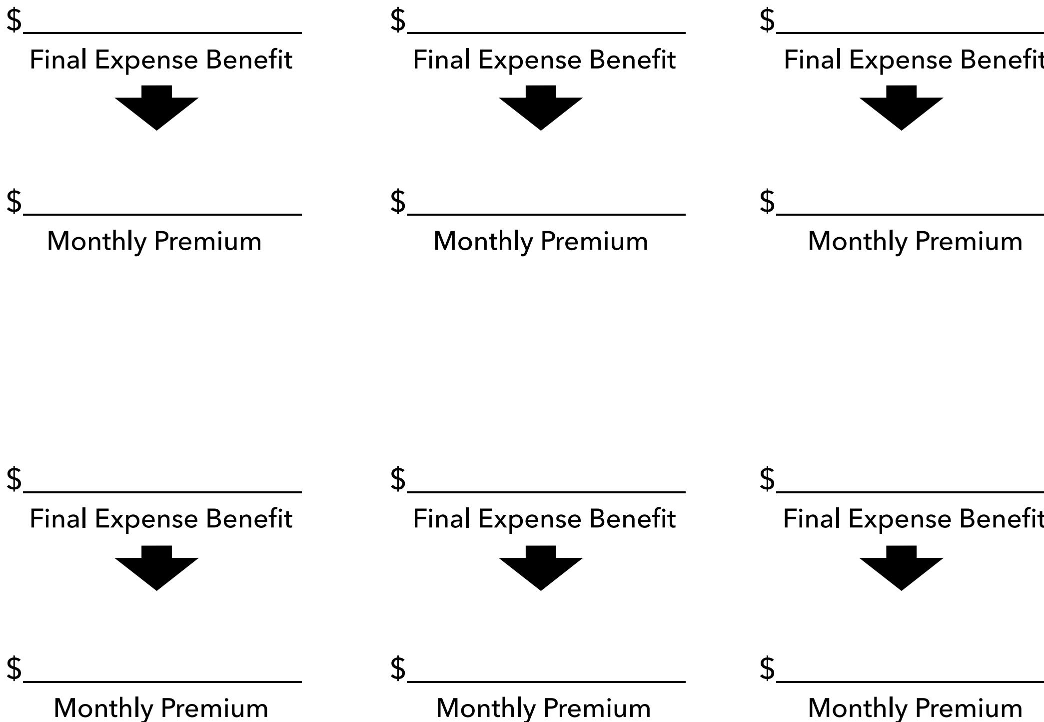
Health Questions

- In the past twelve (12) months, has the applicant used any form of tobacco?………………………………………………… ☐ Yes ☐ No
- Has the applicant tested positive for HIV or been diagnosed by a physician as having AIDs or a life expectancy of twelve (12) months or less?……………………………………………………………………………………… ☐ Yes ☐ No
- Is the applicant currently bedridden, hospitalized, in a care facility, or receiving hospice care?………………………………… ☐ Yes ☐ No
- Receive assistance with daily living activities such as taking medications, bathing, toileting, dressing, or eating?…………… ☐ Yes ☐ No

Has the applicant ever been diagnosed with, been treated by a doctor, or taken medication for any of the following conditions:

- Disease of the heart, including heart attack, heart surgery or congestive heart failure or nitroglycerin?…………………… ☐ Yes ☐ No
- Disease of the circulatory system, including stroke, aneurysm, seizure, lupus, sickle cell anemia or been advised to have surgery to improve circulation?……………………………………………………………………………………………… ☐ Yes ☐ No
- Cancer, other than basal cell skin cancer?………………………………………………………………………………… ☐ Yes ☐ No
- Disease of the lungs, including COPD, chronic asthma or the use of oxygen, nebulizers?……………………………………… ☐ Yes ☐ No
- Disease of the liver or kidney, including insulin dependent diabetes, Hepatitis B or C, or had an organ transplant?………… ☐ Yes ☐ No
- Complications of diabetes, such as amputation, diabetic coma, blindness, neuropathy or kidney disorder?……………………… ☐ Yes ☐ No
- In the past twelve (12) months, has the applicant been confined to a hospital more than twice or had any surgeries?……… ☐ Yes ☐ No
  - If yes, when, how many times and what for? ____
- Recommended to have counseling for alcohol, drug abuse, convicted of a DUI, felony or on parole?………………………… ☐ Yes ☐ No
  - If yes, how recently? ____
- Depression, bipolar disorder, schizophrenia, or memory loss including Alzheimer's, dementia or ALS (Lou Gehrig's disease)?.. ☐ Yes ☐ No
- Current Medications: IF THEY HAVE DIABETES - A1C LEVELS: **AGE DIAGNOSED AT:**

PERMANENT COVERAGE that protects you your whole life.
Premiums **NEVER** increase. Benefits **NEVER** decrease.
You're **PROTECTED** from **THE FIRST DAY** your policy is in effect.
Policy **NEVER EXPIRES** or cancels (*as long as premiums are paid*).
Coverage **CAN NOT BE CANCELLED** because of age or health changes.
BENEFITS PAY OUT within a few business days of claim approval.
When questions or changes arise your agent is there **READY TO HELP**.



$____________________	$____________________	$____________________
Final Expense Benefit	Final Expense Benefit	Final Expense Benefit
$____________________	$____________________	$____________________
Monthly Premium	Monthly Premium	Monthly Premium

$____________________	$____________________	$____________________
Final Expense Benefit	Final Expense Benefit	Final Expense Benefit
$____________________	$____________________	$____________________
Monthly Premium	Monthly Premium	Monthly Premium

Accelerated Death Benefit: ______________

Accidental Death Benefit: $_______________

PRE-QUALIFYING WORKSHEET

This worksheet is necessary to initiate underwriting. Please complete all information **before** you call the company's verification line or complete the e-app. This worksheet contains sensitive information and should be kept secured for your records or destroyed. **Do not send in this form.**

Company________________________Policy #______________________________Date_______________

Annual Premium _______________ Comp.____________

PROPOSED INSURED

Full Name: Date of Birth: Present Age:

Sex: ☐ M ☐ F Height: Weight: State / Country of Birth:

Home Address (*Street, City, State, Zip*):

Home Phone: Cell Phone: Email:

SSN: Driver's License / State ID #: Exp. Date:

Physician Name: City, State, Zip:

OWNER/PAYOR *(Complete only if Owner / Applicant is different from Proposed Insured)*

Full Name of Policy Owner: Date of Birth: Present Age:

Sex: ☐ M ☐ F Relationship to Proposed Insured: State / Country of Birth:

Home Address (*Street, City, State, Zip*):

Home Phone: Cell Phone: Email:

SSN: Driver's License / State ID #: Driver's License State:

PLAN & PAYMENT INFO

Plan Name: Plan Type: ☐ Level (*Preferred*) ☐ Level (*Standard*) ☐ Graded ☐ Modified

Amount Applied For: $ Premium Amount: $ AD&D Rider: ☐ Yes ☐ No

Name of Financial Institution: Account Type: ☐ Checking ☐ Savings

Routing #: Account #:

Initial Premium Payment (*select one*): ☐ Deduct Immediately Upon Approval / Issue
☐ Deduct On or After: ________ / ________ / ________

Ongoing Monthly Auto Payment (*select one*): ☐ Specific Day: (*1st through the 28th*): ______
☐ Specific Week & Weekday: *Week* (*1st, 2nd, 3rd, 4th*):______ *Day* (*Mon, Tue, Wed, Thu, Fri*):______

BENEFICIARY(IES)

☐ Primary ☐ Contingent (% of proceeds ______)

Full Name:

Relationship: DOB:

Phone: SSN:

☐ Primary ☐ Contingent (% of proceeds ______)

Full Name:

Relationship: DOB:

Phone: SSN:

REPLACEMENT *(if applicable)*

Do they have current / pending insurance with this or any other company? ☐ Yes ☐ No

Is the insurance applied for intended to replace or change any current coverage? ☐ Yes ☐ No

	Insurer Name	Policy #
1		
2		
3		

EMERGENCY CONTACT SHEET

According to the "**National Unclaimed Property Network**", twenty percent (20%) of all Life Insurance Policies become lost and are turned over to the State Unclaimed Property Departments, because surviving family members never knew the policies existed. Millions of dollars in Life Insurance go unclaimed every year.

As an additional service to you, we will contact your local emergency contact list. We will provide them with our contact information, a business card, and any additional information they may want or need. Your family will not be alone when the time comes, your family will know who to contact to make sure your policy does not go unclaimed.

I,______________________________, would like the following people notified, regarding my insurance policies and any money that should be paid out, upon my passing.

______________________________ ___________
(signature) (date)

Emergency Contacts:

Name: ______________________________
Address: ______________________________
____
Phone: ______________________________
Relationship: ______________________________

Name: ______________________________
Address: ______________________________
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Phone: ______________________________
Relationship: ______________________________

Name: ______________________________
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