Life application for a Preliminary Application for Life Insurance

Full legal NAME: _____

Date of birth:_____ **Place of Birth:** _____

SocSec # _____

Driver Lic # _____**State** _____

Phone # Home: ( ) -

Phone # Work: ( ) -

E mail _____

Martial Status: [ ]MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOWED

Name of spouse:_____

Spouse date of birth_____

Maiden name _____

Home address:_____

_____

_____**How long at this address** _____

EMPLOYER_____

ADDRESS:_____

_____

YOUR PROFESSION / TITLE:_____

EXACT DUTIES_____

Number of years at current profession / field _____

Personal Physicians name or last physician seen:

Dr._____

Drs ph # _(_____)_____date of last visit_____

Are you a US citizen ? [ ]Yes If no RES ALIEN # _____

Do you Smoke [ ] Yes [ ] No
If yes [ ] cigarette / [ ] cigars / [ ] Tobacco Chew / ( ) times a day

Your Height _____**ft** _____**ins/ Your Weight** _____**lbs**

_____**Sign/ date**

Children:

1 st Child Name _____

Last Name _____
(Leave blank if same as Inssured)

Date of Birth_____
Soc Sec: _____**Sex M / F Full Time Student ? Y / N**

2nd Child Name _____

Last Name _____
(Leave blank if same as Inssured)

Date of Birth_____
Soc Sec: _____**Sex M / F Full Time Student ? Y / N**

3rd Child Name _____

Last Name _____
(Leave blank if same as Inssured)

Date of Birth_____
Soc Sec: _____**Sex M / F Full Time Student ? Y / N**

4th Child Name _____

Last Name _____
(Leave blank if same as Inssured)

Date of Birth_____
Soc Sec: _____**Sex M / F Full Time Student ? Y / N**

Personal Information

CURRENTLY OR EVER HAD A VALID PILOT'S LIC. ? **YES / NO**

DO YOU RACE CARS OR MOTORCYCLES ? **YES / NO**

HAVE YOU OR ARE YOU A CERTIFIED SCUBA DIVER ? **YES / NO**

IN PAST THREE YEARS HAS YOUR DRIVERS LIC SUSPENDED ? **YES / NO**

HAVE YOU EVER BEEN DECLINED FOR ANY KIND OF INSURANCE ? YES / NO

TOTAL ANNUAL INCOME :_$ _____

APPROX. NET WORTH:_____

RENT / OWN HOME ? RENT _____ OR VALUE_____

MORTGAGE BALANCE:_____

FATHERS AGE AND HEALTH (at death if deceased) _____

Mother's " " " " " " " _____

TWO REFERENCES (non relatives):

Name: **ph..:**

Profession: **Yrs.. known:**

Name: **Ph.:**

Profession: **Yrs. known:**

TOTAL AMOUNT OF INSURANCE IN FORCE AT PRESENT

Insurance Company	Amount of Insurance	Year Issued / Policy #

Do you plan to cancel ANY OF THESE POLICIES IF YOU ARE APPROVED FOR THE NEW PLAN ? YES_____ NO_____

_____**Sign/ date**

Beneficiary Information

Name of Trust	
Type of Trust	
Date of Trust	
Name and Phone # of Attorney	

INCLUDE a copy of the First Page of your Trust.

If you do not have a Trust Set up as yet then complete:

PRIMARY BENEFICIARY__

Name:			
Phone:			
Address:	**Street**		
	City		
	State		**Zip**
	Country		

RELATIONSHIP TO INSURED_____

SECONDARY BENEFICIARY(s)

Name:			
Phone:			
Address:	**Street**		
	City		
	State		**Zip**
	Country		

RELATIONSHIP TO INSURED_____

_____**Sign / Date**

ALL MEDICAL QUESTIONS MUST BE ANSWERED

HEALTH STATEMENTS

1. Have you ever (in Oregon - within the last 10 years) sought medical advice or been treated for or been diagnosed as having: If "Yes," circle the disorder.

a. high blood pressure or any heart or circulatory disease or cardiovascular disorder? Y / N

b. epilepsy, seizure disorder, or any disease or disorder of the brain or nervous system? Y / N

c. duodenal or gastric ulcer, gall bladder disease or any other disease or disorder of the stomach, liver, intestines or rectum? Y / N

d. diabetes, kidney stone, abnormality of the urine, or any disease or disorder of any genito-urinary organ? Y / N

e. cancer, tumor, lymph gland disorder, or any other malignant or benign growth? Y / N

f. any disease or disorder of the lungs or respiratory system? Y / N

g. any mental or emotional disorder or psychiatric condition? Y / N

2. Have you ever:

a. been diagnosed by a member of the medical profession as having or received treatment for AIDS or AIDS Related Complex? Y / N

b. tested positive for Human Immunodeficiency Virus (HIV)? (Arizona, North Dakota and Wisconsin residents need not respond. California residents need only reveal results of HIV tests for the purpose of obtaining insurance.) Y / N

c. used alcohol to a degree that required treatment or advice from a physician or licensed practitioner or at an alcohol treatment facility? Y / N

d. attempted suicide? Y / N

e. had any surgical operation performed or recommended? Y / N

f. been diagnosed or treated for a blood disorder or anemia within the last 10 years? Y / N

LIST AND EXPLAIN ANY "YES" ANSWERS TO QUESTIONS 1 THROUGH 2 ABOVE:

Ques #	Nature and Severity of Condition & Frequency of Attacks	Dates of		Name and Address of Physician / Hosp.	Date Last seen Physician for this condition or illness
		Onset	Recovery		

Sign and Date: _____

3. (A) Are you currently taking any medication or treatment Y / N

(B) Have you submitted to any tests or taken medication or treatment in the last 180 days: Y / N

Type of Medication	Date started and frequency	For : Condition or Illness

4. During the past five years, have you:

a. sought medical advice or been treated for cholesterol of triglycerides? Y / N

b. had or been advised to have an X-ray, blood test (excluding HIV test), or electrocardiogram? Y / N

c. seen a physician, been under observation, care or treatment in any hospital or other treatment facility? (Wisconsin residents need not disclose HIV test results received at alternate test sites.) Y / N

5. Do you currently use or within the past five years have you used or been treated for the use of barbiturates, heroin, cocaine, opiates, amphetamines, marijuana, hallucinogens, or any other drug or narcotic, except as prescribed by a physician? Y / N

Type of Drug	Date started and frequency	Date Last Used

6. Have you gained or lost more than 10 pounds in the last year? Y / N

When and where would you like to receive a call from the insurance underwriter ?

[ ] At Home [ ] At Work

[ ] 8am - 11am [ ] 12noon to 4pm [ ] 5pm - 8pm

_____ _____

Signature **Date**

Full Legal Name and Date of Birth.

THIS IS NOT AN APPLICATION. Its information required to complete an application for Life Insurance. You have read the questions and answered them the best of your knowledge and with complete honesty. NO LIFE INSURANCE IS IN FORCE TILL AN INSURANCE CARRIER WILL APPROVE AND YOU HAVE PAID THE PREMIUMS AND SUCH MONIES HAVE BEEN Received BY THE INSURANCE COMPANY. You must review the policy for errors and accuracy, after you have paid all premiums and received the policy you will have a 10-20 days of a LOOK OVER period in which time you may cancel your policy and receive all monies without any obligation or costs. NO RESON FOR THE CANCELATION IS REQUIRED.