QUALIFICATION QUESTIONNAIRE

Insured Information:

Insured's Full Name: ____

Date of Birth: _________________ Birth State: __________ Social Security Number: ___________________

Driver's License: ____________________________ Driver's License Expiration Date: ________________

Home Address: ____

Email: ___________________________________ Phone: ____________________

Is the insured a child? □ Yes □ No *(If yes, parent must complete owner information section)*

Owner Information *(If different from Insured)*:

Will there be multiple owners? □ Yes □ No

Owner's Full Name: ____

Date of Birth: _________________ Birth State: __________ Social Security Number: ___________________

Driver's License: ____________________________ Driver's License Expiration Date: ________________

Home Address: ____

Email: ___________________________________ Phone: ____________________

Employment

Work Name and Address: ____

How long employed with employer: _________ Your Title: ___________________

Current Annual Income: _________________

Medical

Doctors Name and Address: ____

Date last seen by doctor: _____________ Reason and Result of visit: ________________________________

Height: __________ Weight: ___________ Any health issues or surgeries in the last 5 years: □ Yes □ No

If yes, please list: ____

____

Any driving citations in the last 5 years? □ Yes □ No If yes, for what? __________________________________

Medications: ______________ Dosage: ______________ Diagnosis: ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Are you a smoker? ☐ Yes ☐ No If yes, how long? ____________

Beneficiaries

Primary Beneficiary (1): ________________________ Relationship: ______________

Date of Birth: ____________ Social Security Number: ____________________

Primary Beneficiary (2): ________________________ Relationship: ______________

Date of Birth: ____________ Social Security Number: ____________________

Contingent Beneficiary (1): ________________________ Relationship: ______________

Date of Birth: ____________ Social Security Number: ____________________

Contingent Beneficiary (2): ________________________ Relationship: ______________

Date of Birth: ____________ Social Security Number: ____________________

Banking Information

Name of Bank: ________________________________

Routing Number: ________________ Account Number: ________________

Desired Monthly Withdrawal Date: ________ *(Choose a date between 1st and 28th)*

Family History *(This part should be completed only if the application is non-medical).*

	Deceased	Age	Health Concerns/Diagnosis
Father	☐ Yes ☐ No	_______	______________________
Mother	☐ Yes ☐ No	_______	______________________
Brother	☐ Yes ☐ No	_______	______________________
Brother	☐ Yes ☐ No	_______	______________________
Sister	☐ Yes ☐ No	_______	______________________
Sister	☐ Yes ☐ No	_______	______________________