E-App Checklist

Name: First _____ MI _____ Last _____
Email Address: _____@_____._____
Place of Birth: City _____ State_____ Country _____
DOB _____ SS# _____ Gender: **Male or Female** US Citizen: **Yes or No**
Marital Status _____ Height: _____ Weight: _____
Tobacco User?(Cigarettes, Cigars, E-Cig, Patch, Vapor) Yes or No
If Yes, when was tobacco last used?(MM/YYYY) _____
Driver's License: State _____ Number _____ Expiration Date _____
Resident Address _____ City _____
State ____ Zip Code _____Years there_____ **Same address on license?** Y / N ***(If No write down license address)*** Cell#:_____ Home#:_____ Work#:_____
Employer's Name _____Type of business_____
Date of Employment(MM/YYYY) _____ Occupation/ Title _____
City _____ State _____ Annual Income _____ Net Worth _____

Plan of Insurance	Face Amount	Premium Mode	Premium Amount	Amount Paid with Application

Primary Beneficiary:

Name (First, MI, Last)	Relationship	Gender	DOB	SS#	% Payable

Contingent Beneficiary:

Name(First, MI, Last)	Relationship	Gender	DOB	SS#	% Payable

Current Insurance and Replacement:

Company	Policy #	Year Issued	Insured Name	Plan Type	Face Amount	Replace?

If Replacing, what is the reason for replacement? No Living Benefits Higher Cost and/or _____
1035 Exchange: Yes / No If yes, Amount $_____ Company_____Policy #_____

NEED VOIDED CHECK Bank Name:_____
Bank Address:_____
Routing #:_____ Account #:_____ Type: Checking / Savings
Draft Upon Approval? Y / N If No, Desired Day of the Month for Draft: _____

Family Physician: Name _____ Phone# _____
Address _____
Date of last visit(MM/YYYY) _____ Reason: _____

Family History:	Living? Age?	Deceased? Age of Death?	Cause of Death
Father			Internal Cancer or Melanoma? Age at Diagnosis & Type:
Mother			Internal Cancer or Melanoma? Age at Diagnosis & Type:

Does Anyone in the Immediate Family have a history of Heart Disease or Stroke/Cerebral Vascular Accident?
Yes / No If Yes, Age at Diagnosis:_____

Family History cont'd:	Living? Age? M/F?	Deceased? Age of Death?	Cause of Death
Siblings			Internal Cancer or Melanoma? Age at Diagnosis & Type:

Health Conditions:

_____

_____

Medication Name(s)	Condition or Disorder Medication is Treating	Dosage	Frequency	Prescribing Physician	Beginning Date

Special Instructions:

_____

_____

_____

Date: _____/_____/_____

Location where signatures were collected: signed _____,_____

Applicant

I am applying for life insurance and as such do hereby allow my agent _____ to submit my application on my behalf via electronic means so as to expedite the process and avoid any undue delays.

Applicant Signature: _____

Applicant Printed Name: _____

Agent

I hereby certify that as the agent listed below I have seen the applicant in person and have asked the appropriate questions as necessary in my due diligence as an Insurance agent.

I have known the proposed insured for the following: Yrs _____ Months _____

Agent Signature: _____

Agent Printed Name: _____