GENERIC APPLICATION FOR ELECTRONIC IN-PUT	
PROPOSED INSURED FULL NAME	Place of birth- state/country ☐ M ☐F
Home address (street, city, state and zip code)	Date of Birth Issue age Phone #
Social security number	Driver's license number Issue state
Are you a citizen of USA ☐ Yes ☐ No Country?	Permanent Res. Card #?
Employer and length of time employed	Occupation/Duties
Annual income	Net worth
Household income **OWNER IF OTHER THAN INSURED**	Household Net Worth
Name (print first, middle, last)	Place of birth- state/country ☐ M ☐ F
Home address (street, city, state and zip code)	Date of Birth Issue age
Social security number	Driver license number Issue state
Are you a citizen of USA ☐ Yes ☐ No	Other Country?

BENEFICIARY INFORMATION

1) PRIMARY BENEFICIARY	Age	Relationship	SS#
2) PRIMARY BENEFICIARY	Age	Relationship	SS#
3) CONTIGENT BENEFICIARY	Age	Relationship	SS#

GENERAL INFORMATION

1. During the last 5 years have you plead guilty to or been convicted of any moving violations or DUI or have you had a suspension? ☐ YES ☐ NO
2. Have you ever been convicted of a felony or a misdemeanor? ☐ YES ☐ NO
3. Have you been or are you currently involved in bankruptcy that has not been discharged? ☐ YES ☐ NO
4. Do you participate in any motor sport, automobile, motorcycle, boat or marathon racing; scuba, skin, sport or sky diving; parachuting; hand gliding, bungee jumping, mountain climbing, rodeos, snowmobiling? ☐ YES ☐ NO
5. Do you participate in any aviation activity other than as a fare paying passenger? ☐ YES ☐ NO
6. Are there any existing life, disability or annuity contracts? ☐ Yes ☐No
   Company.....Amount.....Policy number----------
7. Have you ever applied for life, health or disability insurance that was rated or declined? ☐ YES ☐ NO
8. In the past 12 months have you applied for or do you have pending life or disability applications? ☐ YES ☐ NO
9. Is the policy being applied for intended to replace any in force life or annuity contracts? ☐ YES ☐ NO
10. Ever tested positive for exposure to the HIV infection or been diagnose as having ARC or AIDS? ☐ YES ☐ NO
11. Have you ever been diagnosed with, consulted a medical professional for, falls, paralysis, numbness, tremors, imbalance or any condition which causes limited motion? ☐ YES ☐ NO
12. Have you been diagnosed with, consulted a medical professional for, been treated or advised to be tested for of treated for memory loss, confusion, and amnesia? ☐ YES ☐ NO

12. Do you currently:
    a. Use or require the use of any mechanical devices such as; a wheelchair, walker, multi-prong cane, hospital bed, dialysis machine, respirator oxygen, motorized cart or stair lifts? ☐ YES ☐ NO
    b. Need help assistance or supervision in: taking medication, doing housework, laundry, and shopping or meal preparation? ☐ YES ☐ NO
    c. Need assistance or supervision: bathing, eating, dressing, toileting, transferring, continence? ☐ YES ☐ NO

FAMILY HISTORY:

	Age if alive	Health	Age at death	Cause of death
Father				
Mother:				
Siblings				

Name, address , phone number of personal physician:
Date last seen:
Reason consulted and outcome:

MEDICAL QUESTIONAIRE

1. Height_____ Weight_____
2. Are you taking any medication? If yes, list type, dose and frequency_____
3. Have you used any type of product containing tobacco within the last five years? □Yes □No
   Product type----------Frequency----------Date last used.
4. Within the past 5 years have you worked less than full time, received or applied for disability or workers compensation? □Yes □No.
5. In the past 10 years have you ever been diagnosed or treated by a licensed professional for:
   a) Heart attack, heart disease, palpitations, heart murmur, chest pain, high blood pressure, stroke, anemia or any other disease of the blood or circulatory system? □Yes □No
   b) Emphysema, asthma, shortness of breath, bronchitis, tuberculosis, disorder of the throat or nose, sleep apnea or any disease of the lungs or respiratory system? □Yes □No
   c) Disorder of the nervous system, dizzy spells, epilepsy, convulsions, paralysis, brain or eye disorders or headaches? □Yes □No.
   d) Disease of the liver, stomach, intestine, pancreas, hepatitis, gallbladder, colon or any digestive system disease? □Yes □No.
   e) Spine, hip, knee, shoulder, back, bones, muscles, arthritis, thyroid, gout, joints? □Yes □No.
   f) Urinary disease, protein, sugar or blood in the urine, kidney, breast, prostate, bladder? □Yes □ No
   g) Depression, anxiety, bipolar, memory loss, Alzheimer's, dementia, PTSD? □Yes □No
   h) Cancer, polyp, other tumors? □Yes □No.
   i) Diabetes or high blood sugar? □Yes □No

6) Treated or diagnosed for a disease or condition that resulted in you having an amputation? □Yes □No

7) Autoimmune disorder such as lupus, blindness, or polio, Parkinson, Huntington's, Lou Gehrig's, Multiple Sclerosis, Motor Disease? □Yes □No

8) In the past 10 years have you used marijuana, cocaine, heroin or any other illicit drug or controlled substance? □ Yes □No

9) Within the past 5 years have you consulted a physician or had x-rays, EKG, or other diagnostic test, been admitted to a hospital or do you plan to enter a hospital within the next 30 days or have any pending doctor's appointment? □Yes □No.

10) Family history of cancer, heart disease, Huntington's disease or Kidney disease? □ Yes □No

PREMIUM INFORMATION

Premium Mode.....Annual.....Semi-annual.....Quarterly.....Monthly (Electronic Funds Transfer)

Face amount Premium Rate Class

BANK INFORMATION:

Name of Bank/Address
Bank routing number:
Bank account number:
Bank phone number:

I authorize .....to draft premiums from my..... Checking.....Savings

Depositor (print name) _____ Depositor (signature) _____

It is represented that the statement and answers given are true, complete and correctly recorded to the extent allowed by the law. I waive my rights to prevent disclosure of any knowledge or information about the questions answered in this document. This waiver applies to any health care provider, physician hospital or other persons who has attended or examined me, or who has been consulted by me. I authorize such persons to make such disclosure and may testify to their knowledge. This authorization is made on behalf of me and any person who shall have or claim any interest in any contract or insurance issued on this application.

Signed at (City/State_____ on _____

_____ _____

Proposed insured (print) Proposed Insured (sign)

Agent's statement: I certify that I have truly and accurately recorded on this form the information supplied by the proposed insured.

X_____

Signature: (Witness/Agent)