

Life Insurance Questionnaire

Name: _____ Date: _____

Address: _____ Phone: _____

_____ Best Time to Call: _____

Date of Birth: ____ ____ ____ Gender: _____

Height: _____ Weight: _____

Type of Coverage (Term, Permanent): _____ If Term, how long? (10,20,30 yrs): _____

Amount of Coverage Desired: _____

1. Do you use any form of Tobacco?

Yes No

2. Have you ever been treated or sought treatment for diabetes, heart disease, cancer or cardiovascular disease?

Yes No

3. Have you ever sought treatment or been advised to seek treatment for the use of drugs or alcohol?

Yes No

4. Have you been treated for depression?

Yes No

5. In the past five years, have you been convicted of driving under the influence of alcohol?

Yes No

6. In the past three years, have you been convicted of 3 or more moving violations?

Yes No

7. Are you currently taking any medications?

Yes No

If Yes, please list the medication and reason for taking:

8. Do you engage in sports such as auto racing, rock climbing, scuba diving, airline piloting?

Yes No

9. Do you plan to travel outside of the US and Canada within the next 12 months?

Yes No