Life Application Questionnaire

Name________________________________Date of Birth _________________

Height ________________ Weight_________________Tobacco Use________________

Spouse ______________________________Date of Birth __________________

Height ________________ Weight_________________Tobacco Use________________

Child _______________________Date of Birth_____________Sex _____Ht.____Wt___
Child _______________________Date of Birth_____________Sex _____Ht.____Wt___
Child _______________________Date of Birth_____________Sex _____Ht.____Wt___
Does any child use Tobacco Products?_____________________

County _____________________________ Home Phone________________________

Address______________________________ Work Phone ________________________

City ________________________________ State _____________Zip________________

Your Occupation________________________________ Spouse's___________________

Type of Coverage: Permanent _______Term ________ Amount of Coverage:______________

(1)
Within the last 10 years: Have you or anyone you want us to insure had Cancer, Diabetes, HIV, Aids, Allergies, Asthma, Arthritis, Seizures, Stroke, Heart trouble, Back problems, High blood pressure, Alcohol abuse, Mental (including depression) or Drug abuse problems, or any other chronic disease? _________ If yes please explain.

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(2)
Have you or anyone been in the hospital or had symptoms, pursuing medical treatment in the last 10 years________ If yes, please explain.

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(3)
Please list all Prescription Drugs you or anyone you want us to insure are presently taking or have taken in the last 10 years.

______________________ ___________________________ ______________________
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(4)
Are you or anyone else you want us to insure, pregnant?______ If so when is the baby due?____

(5)
Have had a parent or sibling die of a disease or sickness before age 60?___________