



LIFE INSURANCE PROPOSAL REQUEST FORM

Agent: _____ Email: _____
Address: _____ City/State/Zip: _____
Phone: _____ Fax: _____ Request date: ___/___/___ Need by: ___/___/___
Delivery method desired: FAX / E-MAIL / MAIL

CLIENT INFORMATION:

Name: _____ Age: _____ DOB: ___/___/___ Save age: Y / N
 Male Female Super Preferred Preferred Standard Better Standard
Height: _____ Weight: _____ Resident State: _____
Tobacco Usage: Y / N Date last used: _____ How often: _____
Type: Cigarettes Cigars Chew/Dip Nicotine Patch/Gum/Pill

Medical History / Medications: *List any health concerns: hypertension, cancer, diabetes, cardiovascular, sleep apnea, etc

Family History:
Did either parent die before age 60? Yes No If yes, cause of death: _____
Have you had family members (parents or siblings) diagnosed with cancer or cardiovascular disease, prior to age 70?
Relationship: _____ Age of onset: _____ Age at death: _____

PRODUCT:

Insurance Amount(s): _____ Company Preference: _____
Riders: Waiver of Premium ADB Child _____ # of units
Term: YRT 5 Year 10 Year 15 Year 20 Year 25 Year 30 Year Return of Premium
Universal Life: Length of Guarantee: Lifetime Guarantee to Age: _____ 1035X/Lump Sum: _____
Premium Length: All Years Solve Premium \$ _____ Number of years to pay premium _____
Whole Life: Premium Length: All Years Solve to pay _____ years.

ADDITIONAL INFORMATION: (driving history, hazardous activities, aviation)

**Some medical conditions such as cancer or cardiovascular disease may require additional information.*