



LIFE INSURANCE QUESTIONNAIRE – FOR PERSONAL COVERAGE

Name: _____ Male Female State: _____ Phone: _____

DOB: _____ Height: _____ Weight: _____ Email: _____

Requested Insurance: Type: Term/Yrs _____ Permanent (Whole Life, Universal Life, etc.)

Face Amount(s): _____

Current Medical Issues (i.e. high blood pressure, diabetes, cholesterol, cancer, sleep apnea, etc.):

Current Medications taken (include type, amount & frequency):

Immediate Family Medical Issues (i.e. high blood pressure, diabetes, cholesterol, cancer, etc.):

Mother:

Current Age: _____ Age at Death: _____ Cause of Death: _____

Father:

Current Age: _____ Age at Death: _____ Cause of Death: _____

Current/Prior Tobacco Use (cigarettes, cigars, chewing tobacco):

Type: _____ Amount: _____

Frequency: _____ Date Last Used: _____

Foreign Travel History (include last 2yrs.) and/or Future Travel Plans:

List any DMV issues within past 5yrs:

Do you have current coverage?: Yes No Company: _____ Amt: _____ Type: _____

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