EQUITY BROKERAGE
OUR GOAL IS YOUR SUCCESS.

Client Application
888.763.9701

Date: _____

Agent Information:		
Name:	Phone #:	Alt. Phone #:
E-mail:	Relation to Insured:	Years Known:

Proposed Insured				
Name:	D.O.B.:	Sex: ◯ M ◯ F	Height:	Weight:
Address:	City:	State		Zip
Home Phone:	Work Phone:	Cell:		
Best time to contact:	Preferred Contact Number: ◯ Home ◯ Work ◯ Cell	E-mail:		
Driver's Lic. #:	SSN #:	US Citizen: ◯ Y ◯ N	Birth Place:	
Occupation:	Annual Income: $ _____	Assets: $ _____	Liabilities: $ _____	

Rate & Plan Information			
Carrier:	Plan:	Face Amount:	Rate Class:
Modal Premium:	Mode: ◯ Annual ◯ Semi-Annual ◯ Quarterly ◯ Monthly		
Payment Plan: ◯ Credit ◯ EFT	Riders:	Bind: ◯ Yes ◯ No	
Existing Insurance:			
Do you plan to cancel another policy & replace it with this one?			
Purpose for Insurance:			

Owner Information			
Is the insured the owner of the insurance policy? ◯ Y ◯ N ☑ If yes, please skip this section. If No, please provide owner/trust information.			
Owner/Trust Name:	Trustee Name:		
Street Address:	City:	State:	Zip:
Tax ID#:	Trust Date:	Trust State:	Trust Type: ◯ Revocable ◯ Irrevocable

Beneficiary Information Add additional sheets as needed for additional trusts			
Primary #1:	Full Name:	D.O.B.	_____%
	Relationship:	SSN #:	
Primary #2:	Full Name:	D.O.B.	_____%
	Relationship:	SSN #:	
Contingent #1:	Full Name:	D.O.B.	_____%
	Relationship:	SSN #:	
Contingent #2:	Full Name:	D.O.B.	_____%
	Relationship:	SSN #:	

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Client Health Screener
888.763.9701

Date: _____

Client Information			
Name:		D.O.B.:	Sex: ◯ M ◯ F
State of Residence:	Guaranteed Term:	Height:	Weight:

Health Information		
1. Have you ever used tobacco products? (i.e. Cigarettes, Cigars, Pipe, Chewing Tobacco, Nicotine patch/gum)	◯ Y ◯ N	❒ If yes: Types: _____ Last Usage: / / How often (#/day)?_____/_____
2. Have you ever been treated for high blood pressure?	◯ Y ◯ N	❒ If yes, fill out the following: Year started:_____ Pressure:_____/____(Sys / Dia) Meds: _____
3. Have you ever been treated for high cholesterol?	◯ Y ◯ N	❒ If yes, fill out the following: Year started:_____ Levels:_____/_____(Total/HDL) Meds Taken: _____
4. Do you participate in any hazardous activities? (i.e. Skydiving, scuba, pilot, racing, etc.)	◯ Y ◯ N	❒ If yes, please list activities, how often & dates: _____
5. Have you ever been convicted of drunk driving DUI/DWI, reckless driving, or had your license suspended or revoked?	◯ Y ◯ N	❒ If yes, date of conviction: _____
6. Have you received any moving violations/tickets (not parking tickets) within the last 5 years?	◯ Y ◯ N	❒ If yes, please list all and date: _____
7. Have you ever been declined for life insurance?	◯ Y ◯ N	❒ If yes, why? _____

8. Have you ever been treated for any of the following conditions?(Check all that apply):

☐ Alcohol/Drugs	☐ Colitis / Crohn's Disease	☐ Heart Disease	☐ Sleep Apnea
☐ Alzheimer's Disease	☐ Depression	☐ Kidney / Liver Disease	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Mental Illness	☐ Ulcerative Colitis or Ileitis
☐ Cancer:_____	☐ Epilepsy	☐ Multiple Sclerosis	☐ Vascular Disease
☐ COPD	☐ Emphysema	☐ Rheumatoid Arthritis	☐ Other:_____

If yes, please list the condition, date(s) of diagnosis and treatment, and any medications currently being used.

_____

_____

_____

Family History

	Age OR Age of death (if deceased)	Cause of death (if deceased)	History of heart or circulatory disease	History of cancer (all types)	Notes:
Mother			◯ Y ◯ N	◯ Y ◯ N	
Father			◯ Y ◯ N	◯ Y ◯ N	
Sister(s)			◯ Y ◯ N	◯ Y ◯ N	
Brother(s)			◯ Y ◯ N	◯ Y ◯ N	