LIFE INSURANCE QUESTIONNAIRE

Your full name: _____

Your email address: _____

Home Phone: _____

Business Phone: _____

Street Address: _____

City: _____

Zip Code: _____

Amount of Coverage Requested: _____

Personal Information

Sex: _____

Date of Birth: _____

Height: _____

Weight: _____

Do you smoke? ____ Yes ____ No

Type of Insurance Requested: ____ Whole Life ____ Term

How much insurance do you currently carry? _____

Medical History

Have you ever had any indication of the following medical problems?

Heart Disease: _____ Yes _____ No

Cancer: _____ Yes _____ No

HIV: _____ Yes _____ No

Diabetes: _____ Yes _____ No

Cholesterol: _____ Yes _____ No

High Blood Pressure: _____ Yes _____ No

Please explain any “Yes” answers above and any medical problems you may have had in the past ten years:

_____

_____

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