PERSONAL INSURANCE FACT FINDER

Name ______________________________ Phone Number ________________Email Address____________________

Date of Birth_______________ Male/Female__________

COMPLETE FOR LIFE INSURANCE

Amount of Life Insurance Protection requested $_________________ $ __________________ $__________________

Purpose of the Life Insurance: ☐ Family Protection ☐ Debt Protection ☐ Estate Planning
☐ Business Buy-Sell Funding ☐ Business Key Person Protection

Type of Life Insurance:
Term: ☐ 10 yr ☐ 15 yr ☐ 20 yr ☐ 25 yr ☐ 30 yr
Permanent: ☐ Universal Life ☐ Whole Life

COMPLETE FOR DISABILITY INCOME INSURANCE

Occupation and Duties____

Salaried/Hourly Employee Monthly Income $______________________ (W-2 Income, 1099 Income)

Business Owner Monthly Income: $______________ (Net Business Income, Schedule C or K Income, Share of Corporate Profits)

RISK EVALUATION

Tobacco/Nicotine Use:
☐ Never Used any Nicotine Product or stopped more than 5 years ago
☐ Have used: Type ___________ How Often ____________
☐ Stopped Use? When Stopped_______________

Build: Height_____________ Weight_____________

Family History:
Parents, Brothers, Sisters: Died Prior to age 61 of Cardiovascular Disease or Cancer? (Yes/No) _____
If yes, Parent or Sibling?______________ Age at Death____________ Cause of Death_____________
If more than one, provide details of each____

☐ Taking Blood Pressure Medication? If known, last BP reading_______________
☐ Taking Cholesterol Medication? If known, last Cholesterol reading___________

List all medications currently taking ____

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Medical History: Have you ever been told you had, or been treated for any of the conditions listed? If yes, check all that apply.

☐ Alcohol Abuse	☐ Depression/Anxiety	☐ Lupus
☐ Alzheimer's Disease	☐ Diabetes	☐ Multiple Sclerosis
☐ Asthma	☐ Drug Abuse	☐ Peripheral Vascular Disease
☐ Cancer	☐ Epilepsy	☐ Rheumatoid Arthritis
☐ Cirrhosis	☐ Heart Murmur	☐ Sleep Apnea
☐ COPD	☐ Hepatitis	☐ Stroke/TIA
☐ Coronary Artery Disease	☐ Irregular Heartbeat	☐ Neck, Back, Spine
☐ Crohn's Disease	☐ Kidney Disease	☐ Other

Details: Dates of onset, diagnosis, details of treatment:____

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AviationAvocation:
In the past 5 years have you participated in any of the following activities? If yes, provide details below.

☐ Flying ☐ Scuba Diving ☐ Racing ☐ Rock Climbing ☐ Other

Citizenship:
U.S. Citizen? (Yes/No) ________
If no, country of citizenship_______________ Type and date of Visa_______________
Green Card? (Yes/No) _______ How long in the US? ____________

Foreign Travel:
Any plans to travel outside the US or Canada? (Yes/No) ______
If Yes, Countries and cities you will visit, duration of each, purpose of travel _______________________

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In the past 10 years have you had any of the following motor vehicle related incedents? (Yes/No) ______

☐ Moving Violations ☐ Reckless Driving ☐ DUI ☐ License Suspension of Revocation

Details: ____

In the past 10 years used marijuana in any form? (Yes/No) ______

Still using? (Yes/No) ______ If Yes, How often? ________________ In what form? ________________
If quit, when? ___________
Recreational or Medicinal? ________________ If Medicinal, what is the medical reason? ____________

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Additional Details: ____

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