

FACT-FINDER

All personal information protected by HIPAA regulations

Completion of a FACT FINDER will accelerate the underwriting process

Agent name: _____

Agent phone number _____ E-Mail Address: _____

Proposed Insured's legal name: _____ Date of Birth/Age: _____

Plan of Insurance requested:

Individual: Term UL VUL WL

Survivorship: SUL SVUL SWL

Rate Class Desired

Best Rate

Preferred

Standard

Rated: _____

Has this case been discussed or submitted to your BGA on a preliminary, trial, or informal basis? Yes No

Client's budget: \$ _____

Present Nicotine Use:

None Cigarettes—frequency of use per day: _____

Cigars Pipe Dip Chew Nicotine Gum Other: _____

Quantity per month _____

Former Tobacco Use: List each type of tobacco, quantity and frequency used, and date of last use: _____

Build: Height: _____ feet _____ inches Weight: _____ pounds

Family History (Family history is a consideration for each rate class):

To your knowledge, is there any family history (parent or siblings) with onset of disease prior to age 60 due to cardiovascular disease, cerebrovascular disease, diabetes, or cancer? Yes No

If yes, provide full details with impairment, age at onset and age at death if deceased:

Father: _____

Mother: _____

Siblings: _____

Blood Pressure and Cholesterol:

Latest BP reading: _____/_____ Latest total cholesterol: _____ mg Latest cholesterol/HDL ratio: _____

Are you currently taking any medication for blood pressure? No Yes, Name of medication: _____

Are you currently taking any medication to lower cholesterol? No Yes, Name of medication: _____

FACT-FINDER — CONTINUED

Aviation/Avocation:

In the past 5 years have you or do you intend to participate in any of the activities listed?

None Flying Racing Sky diving Scuba diving Other

Details: _____

Citizenship/Residency/Travel:

US Citizen: Yes No

If no, provide type and expiration date of visa, green card status, and length of time in USA: _____

Any future plans to live or travel outside the USA? *check with your Brokerage General Agency regarding state compliance prior to completing any application(s) No Yes (provide purpose, cities, countries, frequency, and duration): _____

Driving History:

Have you had any of the following motor-vehicle-related incidents in the past 10 years?

Moving violation Reckless driving DWI or DUI License suspension License revoked

Provide dates, details: _____

Medical History:

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

- | | | |
|---|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Alzheimer's/dementia/cognitive impairment | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart murmur/valve disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Irregular heartbeat/palpitations | |
| <input type="checkbox"/> Coronary artery or cerebrovascular disease | <input type="checkbox"/> Kidney disease | |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Multiple sclerosis | |

List dates, diagnosis, details, treatment, plus names, addresses, and phone numbers of all physicians consulted
(Refer to Common Medical and Non-Medical Impairment sections for critical underwriting factors):
