Demographics

Proposed insured Name

Proposed insured phone number

Proposed insured email address:

Proposed insured Date of Birth:

Proposed insured SSN #

Proposed insured address

Proposed insured birthplace (city, state)

Proposed insured DL#

DL issue state

DL Expiration date

If no DL, state issue #

State issue expiration

State of issue

Any tickets or offenses on your driving record within the last 10 years. (DUI, tickets, traffic stop)

Beneficiary section

All beneficiaries must be 18 years old or older. Be sure to explain in cover letter if beneficiary is not an immediate family member as they will ask for insurable interests and how the beneficiary listed would be at financial hardship if proposed insured passed.

Primary Beneficiary

Name (First, Last)

DOB

Relationship

Share

SSN

Name (First, Last)

DOB

Relationship

Share

SSN

Name (First, Last)

DOB

Relationship

SSN

Name (First, Last)

DOB

Relationship

SSN

Share

Share

Contingent Beneficiary

Name (First, Last)

DOB

Relationship

Share

Name (First, Last)

DOB

Relationship

Share

Name (First, Last)

DOB

Relationship

Share

Name (First, Last)

DOB

Relationship

Share

Family History

Mother-

DOB

Alive or deceased?

If decided, what age and cause of death

Father-

DOB:

Alive or deceased

If decided, what age and cause of death

Siblings:

Number of siblings

Sibling 1-

Alive/ Deceased

If deceased, what age and cause

Sibling 2-

Alive/ Deceased

If deceased, what age and cause

Sibling 3-

Alive/ Deceased

If deceased, what age and cause

Sibling 4-

Alive/ Deceased

If deceased, what age and cause

Sibling 5-

Alive/ Deceased

If deceased, what age and cause

Sibling 6-

Alive/ Deceased

If deceased, what age and cause

Medical Information- LIST ALL IF THERE ARE MANY

Medical Provider Name

Date of Last Visit

Reason of La~~ts~~ visit

Outcome of last visit

Physicians Name

Physicians Address

Physicians Phone number

Height:

Weight:

Employment Information

Employer Name

Length of Employment

Annual Income

Title

Duties

Annual Income

Household Income

Net Worth

Household Net Worth

Bank Information

Bank Name:

Branch:

Routing #

Account Number

If first payment is a credit card:
Credit card #:

ONLY FILL THIS OUT IF THERE THE PAYOR/ OWNER IS DIFFERENT THEN PROPOSED INSURED

Demographics

Payor/ Owner Name:

Payor/ Owner Phone number:

Payor/ Owner email:

Payor/ Owner address:

Payor/ Owner DOB:

Payor/ Owner SSN #

PAYOR/OWNER IF DIFFERENT THAN INSURED

Employer Name

Length of Employment:

Title:

Duties:

Annual Income:

Household Income:

Bank Information

Bank Name:

Branch:

Routing #

Account #

If first payment is a credit card:
Credit card #:

THIS RELEASHIONSHIP MUST BE PARENT, GRANDPARENT, LEGAL GARDIUAN. IF IT IS A LEGAL GARDIAN PAPERWORK MUST BE COMPLETED.

Relationship to proposed insured:

Underwriting

LIST ANYTHING APPLICABLE WITHIN THE PAST 10 YEARS

Answer **ALL** of these questions accurately to ensure smooth processing. Be sure to include information for 10 years ago by providing dates, doctors name, medication, and if there is any residual effects.

Heart attack? If yes, date of diagnosis, was there hospital emission. If yes include attending physician/facility name, address, and number, results. Does proposed insured currently experience any difficulty due to this diagnosis? Has there been any other hospitalizations or doctor visits made regarding this condition? Any work missed due to this condition? Any medications prescribed currently or previously within the past 10 years in relation to this condition? If yes, include the prescription name, frequency and dosage of each use, and doctor that prescribed this medication name, address, and facility number. Provide date of last checkup regarding this condition, as well as if there was a normal outcome. List any medication prescribed for this condition and include the dose amount, frequency of use, attending physicians name, address, and contact for prescription. Include any medications that are prescribed over the course of this diagnoses even if they were taken. Include herbal/ natural supplements provide name, dosage, and frequency of use. If any medications/ treatments are prescribed but not taken include if there is doctor approval. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Stroke? If yes, date of diagnosis, was there hospital emission. If yes, include attending physician/ facility name, address, and number, results. Does proposed insured currently experience any difficulty due to this diagnosis? Has there been any other hospitalizations or doctor visits made regarding this condition? Any work missed due to this condition? Any medications prescribed currently or previously within the past 10 years in relation to this condition? List any medication prescribed for this condition and include the dose amount, frequency of use, attending physicians name, address, and contact for prescription. Include any medications that are prescribed over the course of this diagnoses even if they were taken. Include herbal/ natural supplements provide name, dosage, and frequency of use. If any medications/ treatments are prescribed but not taken include if there is doctor approval. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

High blood pressure? If yes, when were you diagnosed, physician name, address and contact for the attending physician. Provide blood pressure reading from doctor visits as well ad any other readings that are doing throughout the day (preferably morning, night, evening reading. List any medication prescribed for this condition and include the dose amount, frequency of use, attending physicians name, address, and contact for prescription. Include any medications that are prescribed over the course of this diagnoses even if they were taken. Include herbal/ natural supplements provide name, dosage, and frequency of use. If any medications/ treatments are prescribed but not taken include if there is doctor approval. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Diabetes? If yes, when was diagnosis, type, doctor to diagnosis. If applicable A1c, how many times a day are blood sugars tested, typical glucose reading lowest reading, average reading, a highest reading. Have there been any hospital/ doctors' visits with abnormal results due to this condition? List any medication prescribed for this condition and include the dose amount, frequency of use, attending physicians name, address, and contact for prescription. Include any medications that are prescribed over the course of this diagnoses even if they were taken. Include herbal/ natural supplements provide name, dosage, and frequency of use. If any medications/ treatments are prescribed but not taken include if there is doctor approval. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Cholesterol? If yes, when was diagnosis, doctor to diagnosis, medication/ treatment. List any medication prescribed for this condition and include the dose amount, frequency of use, attending physicians name, address, and contact for prescription. Include any medications that are prescribed over the course of this diagnoses even if they were taken. Include herbal/ natural supplements provide name, dosage, and frequency of use. If any medications/ treatments are prescribed but not taken include if there is doctor approval. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Cancer, of any type? If yes, when was diagnosis, and include diagnosis. Physician name, address, contact information that completed the diagnosis. Provide when the lump/ tumor/ cysts were first discovered, location of the lump, cyst, tumor, and date or removal. Provide physician name, address, and contact that completed the removal. Any treatment following removal? Any remission history if this condition and or currently recovered? Provide the latest appointment date and result regarding this condition and physician information if different from previous physician. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Asthma? If yes, when was the first diagnosed. Provide the name, address, contact information for attending physician related to this disorder. If applicable any medication/ inhalers prescribed and in use, if yes provide the name and frequency of use in accordance with the medication/ inhaler include physician name, address, contact. Any breathing treatments in place, if yes include treatment type, frequency type. Ask to be sure there is no treatment (inhaler/ medication/ breathing treatments that may have been prescribed previously that may not be used include the name of treatment, reason for discontinuing, use as well as doctor approval for discontinuing treatment) Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Anxiety/ Depression: If applicable, provide date of diagnosis, name of medication used in treatment, frequency of use, dosage of each use, attending physicians name, address who prescribed this medication. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Military History: If applicable provide branch name, date enlisted, active duty, side effects, if discharged provide reason as well as discharge date. Be sure to include if there is any diagnosis such as PTSD, or other disorders in relation to proposed insured service. Also, include date of last visit, outcome of last visit as well as physician name, address, and contact.

Drug use of any kind. Include frequency, type, reason. If medical marijuana used get a copy of medical card as well as reason, and attending physician name, address, and contact.

Tobacco use, if yes how often, what type, and duration of use (how many years/ months). If proposed insured was a smoker how long ago, what type.

Is the proposed insured currently taking any prescription medications not previously disclosed on this pre application? (ENSURE UNDISCLOSED INFORMATION CAN SLOW DOWN THE PROCESSING OF THE APPLICATION)

Is the proposed insured prescribed any medication they are not currently taking? If applicable, prove medication name, reason for discounting medication, as well as if there was doctor approval involved. (INCLUDE ANY MEDICATION PRESCRIBED WITHIN THE LAST 10 YEARS TO ENSURE SMOOTH PROCESSING)

Does the proposed insured have any operations, exams, or procedures consulted or scheduled? If yes, provide the name, reason, as well as Doctor name, address, and contact information.

List any incidents that had happened at work.

Any hospitalizations? If yes, provide date range, reason, outcome as well as the hospital name. Any work missed due to this hospitalization. Any consecutive hospital stays?

Are there any diagnosis/ disorders that have not yet been discussed on this application? PROVIDE ANY DIAGNOSIS THAT WAS TALKED ABOUT OR MAY BE CURRENTLY IN DISCUSSION.

List any medication that the proposed insured is prescribed that they no longer take and provide, reason and doctor approval to stop medication.

List any over-the-counter medications, vitamins, and or herbal/ natural supplements being taken. If yes, provide the name, dosage, frequency of use, reason for use.

Have you had COVID-19? If so, when, severity, symptoms, continued symptoms, and attending doctor's name.

Is there any diagnosis, surgery, treatment, medications, consultations, or anything related? to your health within the past 10 years that you have not yet disclosed on this application.

If submitting through Mutual of Omaha be sure to ask the proposed insured if they have recently purchased a home within the last year. If yes, provide purchase date, amount, and lender name.

AGENTS BE SURE TO COMPLETE APPROPRIATE QUESTIONNAIRES FOR CORRELATED CARRIER AND CONDITION TO GET EVERYTHING SUBMITTED TO ENSURE SMOOTH PROCESSING: IF YOU ANSWERED YES TO ANY CONDITIONS BE SURE TO CHECK UNDERWRITING GUIDES FOR CARRIER TO COMEPLETE APPROPIATE QUESTIONNAIRE.