



GPEZ Insurance Request Form

Date: _____

APPLICANT INFORMATION

FULL NAME (include former names)			GENDER M F	DOB (mm/dd/yyyy)	BIRTH STATE	SSN/TIN	
STREET ADDRESS			CITY		STATE	ZIP CODE	YEARS @ ADDRESS
PRIMARY PHONE		SECONDARY PHONE			EMAIL ADDRESS		
DRIVER'S LICENSE #	STATE ISSUED	OCCUPATION / COMPANY			LOCATION (City)		YEARS IN JOB
EARNED INCOME (annual) \$	UNEARNED INCOME (annual) \$	TOTAL HSHOLD INCOME (annual) \$	NET WORTH \$		BANKRUPTCY last 5 years or intention to file: No Yes		

PROPOSED INSURANCE PLAN (To be completed by Agent/Broker)

CARRIER	TYPE TERM UL WL IUL	PRODUCT (term /guar to age)	FACE AMOUNT \$	PREMIUM \$	MODE Mo Semi Qtr Ann	
RIDERS	CLASS QUOTED	HOW SUBMITTED eApp Paper Drop Tkt	DATE SUB'D	PERS or BUS	CVAT or GPT	DB: Inc/Lev 1035 EXCH AMT \$

OWNER (if other than the applicant)

FULL NAME		RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN	DRIVER'S LICENSE #	STATE ISSUED
STREET ADDRESS			CITY	STATE	ZIP CODE	
PRIMARY PHONE		SECONDARY PHONE		EMAIL ADDRESS		

BENEFICIARY INFORMATION (for more space, use Additional Notes on page 3)

FULL NAME	RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN	PERCENTAGE	TYPE
				%	Primary Contingent
				%	Primary Contingent
				%	Primary Contingent

CURRENT & APPLIED FOR POLICIES (past 6 months)

COMPANY	POLICY NUMBER	YEAR ISSUED	FACE AMOUNT	REPLACING?	TYPE*	1035 EXCHANGE?
			\$	Yes No		Yes No
			\$	Yes No		Yes No
			\$	Yes No		Yes No
			\$	Yes No		Yes No

PAYOR / EFT INFORMATION

* Type: i = individual b = business g = group p = pending

PAYOR FULL NAME (if other than insured)		RELATIONSHIP	DOB (mm/dd/yyyy)	SSN/TIN		
BANK		ROUTING NUMBER		ACCOUNT NUMBER	DRAFT DAY	
NAME ON ACCOUNT		DRAFT @ Issue On Receipt Future For TLA	DRAFT DATE	COLLECTED w/ APP \$	BIND COVERAGE? Yes No	



GPEZ Underwriting Questions

Applicant's Name: _____ Date: _____
 Date of Birth: _____

HEIGHT ' "	WEIGHT "	NICOTINE USE: NEVER CURRENT* QUIT*(Date: _____) *TYPE/AMT/FREQ: _____
		ALCOHOL USE: NEVER CURRENT** QUIT(Date: _____) ** TYPE/# PER WK: _____

BLOOD PRESSURE Systolic: _____ Diastolic: _____	CHOLESTEROL Level: _____ HDL Ratio: _____
Taking BP Medication: Yes No	Taking Cholesterol Medication: Yes No

Check any that apply and provide details: condition, onset dates, duration, symptoms, complications, severity, treatment, medication, treating provider, etc.

CARDIOVASCULAR Including but not limited to aneurysm, angina, blood clot, chest pain, coronary artery disease, congestive heart failure, heart attack, heart murmur, irregular heart beat, mini-stroke (TIA), peripheral vascular disease, shortness of breath, stroke, or other disease, disorder or blockage of the arteries or veins, etc.

DIABETES A1c LEVEL: _____ Age Diagnosed: _____ Maintenance: Oral Insulin Diet & Exercise

CANCER Including but not limited to cancer, cysts or other similar abnormalities, leukemia, lymphoma, masses, tumors or growths, etc.

RESPIRATORY Including but not limited to asthma, chronic bronchitis, emphysema, COPD, cystic fibrosis, sleep apnea or other breathing or lung disorder, etc.

OTHER CONDITIONS Including but not limited to AIDS virus, arthritis, connective tissue disorder, Crohn's disease, digestive issues, epilepsy/convulsions, gastric/peptic ulcers, kidney/ liver/pancreas disease, multiple sclerosis, muscle disorders, prostate disease, psychiatric care or counseling, rheumatoid arthritis, ulcerative colitis, etc.

FAMILY HISTORY	Mother	Father	Sibling (gender)	Sibling (gender)	Sibling (gender)
Age if Living					
Age @ Death					
Cause of Death					

PRESCRIPTION INFORMATION List all prescriptions taken in the last 5 years (use notes section if needed)

PRESCRIPTION	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN	TIME PERIOD USED	REASON

PHYSICIAN VISIT/ HOSPITALIZATION / MEDICAL PROCEDURE / SURGERY / DIAGNOSTIC TEST List all last 5 years (use notes section if needed)

PHYSICIAN / FACILITY	CITY / STATE	DATE(S)	REASON / OUTCOME

<p>HIGHER RISK ACTIVITIES <i>Check any activity that applicant engages in / plans to engage in:</i></p> <ul style="list-style-type: none"> Ballooning Bungee jumping Hang Gliding / Parachuting / Sky Diving Motor Sports of any type Pilot / Student Pilot / Flight Crew Rock / Mountain Climbing Scuba / Skin Diving Spelunking 	<p>MISCELLANEOUS INFORMATION <i>Check any that apply to applicant & provide details in notes section:</i></p> <ul style="list-style-type: none"> Had a life insurance application modified, rated, declined, postponed Convicted or awaiting trial for a felony Planning to travel outside the U.S. for business or pleasure in the next 12 months. <i>If so, provide travel dates and indicate which countries.</i> Member of the Armed Forces or planning to apply Pled guilty or no contest to any driving violations in last 5 years, including DUI Not a permanent U.S. citizen Undergoing treatment for alcohol or drug dependency or have in past 5 years
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HOW LONG HAS BROKER BEEN ACQUAINTED WITH APPLICANT: _____



INTERVIEW AVAILABILITY

Applicant's Name: _____ Date: _____

Applicant's Full Name:		
Preferred Dates & Times for Phone Interview: (Mon-Thurs, 8 am - 7 pm/Fri, 8 am - 3 pm ET)		
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS

Owner's Full Name (if different from applicant):		
Preferred Dates & Times for Phone Interview: (Mon-Thurs, 8 am - 7 pm/Fri, 8 am - 3 pm ET)		
PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS

ADDITIONAL NOTES (if needed)

ADDITIONAL SPACE (if needed)

PRESCRIPTION INFORMATION List all prescriptions taken in the last 5 years (use notes section if needed)					
PRESCRIPTION	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN	TIME PERIOD USED	REASON

PHYSICIAN VISIT/ HOSPITALIZATION / MEDICAL PROCEDURE / SURGERY / DIAGNOSTIC TEST List all last 5 years (use notes section if needed)			
PHYSICIAN / FACILITY	CITY / STATE	DATE(S)	REASON / OUTCOME