CLEAR FIELDS

Pre-App Collection Form

Date: _____

Excellent data collection tool for iGo/eApps

App. Last Name: _____

Not an Application for Insurance

APPLICANT INFORMATION

FULL NAME (include former names)	GENDER	DOB (mm/dd/yyyy)	BIRTH STATE	SSN/TIN
	☐ M ☐ F			

STREET ADDRESS	CITY	STATE	ZIP CODE	YEARS @ ADDRESS

PRIMARY PHONE	SECONDARY PHONE	EMAIL ADDRESS

DRIVER'S LICENSE #	STATE	EXPIRES	OCCUPATION / COMPANY	LOCATION (City)	YRS IN JOB

EARNED INCOME (annual)	UNEARNED INCOME (annual)	TOTAL HSHOLD INCOME (annual)	NET WORTH	BANKRUPTCY last 5 years or intention to file:
$	$	$	$	☐ No ☐ Yes Date Discharged:

MARITAL STATUS
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Civil Union
- ☐ Domestic Partner

US Citizen ☐ Yes ☐ No *If "No", complete one of the sections below.*

RESIDENT WITH LEGAL PERM. STATUS:	*TEMPORARY (NON-RESIDENT) WITH VALID VISA:*		
Green Card / Visa Type:	Visa Type:	Visa #:	
Number:	Cntry of Citizenship:	Passport #:	
Expiration Date:	Exp. Date:	Date of Entry (US):	I-94 Exp. Date:

PROPOSED INS. PLAN

CARRIER	TYPE	PRODUCT (term /guar to age)	FACE AMOUNT	PREMIUM	MODE
	☐ TERM ☐ UL ☐ WL ☐ IUL		$	$	☐ Mo ☐ Semi ☐ Qtr ☐ Ann

RIDERS	CLASS QUOTED	HOW SUBMITTED	DATE SUB'D	PERS or BUS	CVAT or GPT	DB: Inc/Lev	1035 EXCH AMT
		☐ eApp ☐ Paper ☐ Drop Tkt					$

POLICY 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

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

CUR. & APPLIED FOR POLICIES *(past 6 mos)*

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

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

PAYOR / EFT INFORMATION

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	DRAFT DATE	COLLECTED w/ APP	BIND COVERAGE?
	☐ @ Issue ☐ On Receipt ☐ Future ☐ For TLA		$	☐ Yes ☐ No

This document is for data collection only and does NOT constitute a formal, binding contract for insurance.

v02/11/21

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:
Taking BP Medication: ☐ Yes ☐ No

CHOLESTEROL Level: _____ HDL Ratio:_____
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, prostrate 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

HIGHER RISK ACTIVITIES

Check any activity that applicant engages in / plans to engage in:

- ☐ 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

MISCELLANEOUS INFORMATION

Check any that apply to applicant & provide details in notes section:

- ☐ 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. ***If so, provide travel dates and indicate which countries.***
- ☐ Member of the Armed Forces or planning to apply
- ☐ Pled guilty or no contest to any driving violations in last 5 years, including DUI
- ☐ Undergoing treatment for alcohol or drug dependency or have in past 5 years

HOW LONG HAS BROKER BEEN ACQUAINTED WITH APPLICANT: _____

Applicant's Last Name: _____ Date: _____

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	DURATION	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