

Confidential Questionnaire

Legal Name (First, MI, Last) _____ Suffix: _____

Gender: _____ Marital Status: _____ DOB: _____ Where Born: _____

SSN: _____ Email Address: _____

Address: _____ How long at address: _____

Mailing Address: _____

Phone: _____ Home Mobile Best time to call: AM PM

Resident U.S. Citizen Non-Resident U.S. Citizen Resident Alien

Driver's License number: _____ State of issue: _____ Exp: _____

Job Title: _____ Year Hired: _____ Employer: _____

Employer Address: _____

Earned Income Estimate (wages before tax/Gross income): Current year _____ Previous year _____

Unearned Income (interest, dividends capital gains, etc.): Current year _____ Previous year _____

Net worth (if everything you owned was sold, and your debts were paid): _____

Amount of net worth that's liquid: _____

Other Insurance or Annuities in-force or applied for:

Company Name	Policy # (if known)	DB Amount	WL, Term, or Annuity	Year Issued	Replacing?
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Beneficiaries:

Full Name	Primary/Contingent	Relation to Insured	Percentage (must total 100%)	Birthdate
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please include an explanation at the end of the document for any of the following questions answered "Yes"

Has proposed insured:

Used tobacco or nicotine products in any form within the last five years? Yes No

Ever applied for insurance or reinstatement which has been declined, postponed, rated, modified; or had any such insurance canceled or a renewal premium refused? Yes No

Ever received or claimed indemnity, benefits or a payment for any injury, sickness, or impaired condition? Yes No

Ever made any flights as a pilot, student pilot, or crew member of any aircraft? Yes No

Been convicted of a moving traffic violation, had any traffic accidents, or had a driver's license revoked or suspended within the past five years? Yes No

Been charged with, or convicted of, or currently awaiting trial on the violation of any criminal law? Yes No

Any intention of traveling or residing outside the U.S. or Canada in the next two years? Yes No

Belong to or intend on joining any active or reserve military, naval, or aeronautic organization? Yes No

Personal/Health Questions:

Primary Care Physician name/office: _____

Physician address: _____ Phone: _____

Date last seen: _____ Reason: _____

Currently taking any medications? Yes No

Medication Name	Dosage	How often taken?	Reason
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Height: _____ Current Weight: _____

Has your weight changed by more than 10 lbs. in the last 12 months? Yes No

Do you have, or have you ever had, any of the following:

- High blood pressure or high cholesterol levels? Yes No
- Disorder of the eyes, ears, nose, or throat? Yes No
- Dizziness, vertigo, fainting, seizures, recurrent headache, speech defect, tremor, neuropathy, paralysis, multiple sclerosis, stroke, transient ischemic attack (TIA), memory loss, dementia, or any other disorder of the brain or nervous system? Yes No
- Shortness of breath, chronic cough, bronchitis, asthma, emphysema, chronic obstructive pulmonary disease (COPD), sleep apnea, or chronic respiratory disorder? Yes No
- Chest pain, irregular heartbeat, heart murmur, heart valve disease, heart attack, coronary artery disease, heart failure, aneurysm, or other disorder of the heart or blood vessels? Yes No

- Intestinal bleeding, inflammatory bowel disease (including Crohn's disease or ulcerative colitis), hepatitis, diverticulitis, recurrent indigestion, or other disorder of the esophagus, stomach, intestines, pancreas, liver, or gallbladder? Yes No
- Sugar, protein, or blood in urine; sexually transmitted disease (excluding HIV); chronic kidney disease, kidney stone, or other disorder of the kidneys or bladder? Yes No
- Diabetes, elevated blood sugar, thyroid, pituitary, adrenal, or other endocrine (glandular) disorders? Yes No
- Disorder of the breasts, reproductive organs, or prostate? Yes No
- Arthritis, gout, lupus, or disorder of or injury to the bones, muscles, wrists, hips, knees, or other joints? Yes No
- Spinal, neck or back disorder or injury, including sprains, strains, or disc disorder? Yes No
- Mass, polyp, cyst, tumor, or cancer? Yes No
- Allergies; disorder of the skin; anemia, bleeding, clotting, or other disorder of the blood? Yes No
- Anxiety, depression, stress, attention deficit hyperactivity disorder (ADHD), eating disorder, or other psychiatric or mental health disorder? Yes No
- Chronic fatigue, chronic pain, fibromyalgia, or fever of unknown cause? Yes No

Within the last 5 years:

Consulted or received treatment from a chiropractor? Yes No

Had a checkup, consultation, illness, injury, or surgery, been a patient in a hospital, rehabilitation center, or other medical facility; had an X-ray, EKG, heart scan, MRI, or CT scan, biopsy, or another diagnostic test (excluding HIV)? Yes No

Been advised by a licensed medical professional to have any diagnostic test (excluding HIV), hospitalization, or surgery which has not been completed? Yes No

Within the last 10 years:

Used marijuana, cocaine, heroin, barbiturates, tranquilizers, hallucinogens, amphetamines, narcotics, or any other drug, except as legally prescribed by a physician? Yes No

Sought, received, or been advised to seek medical treatment or counseling for the use of alcohol or drugs? Yes No

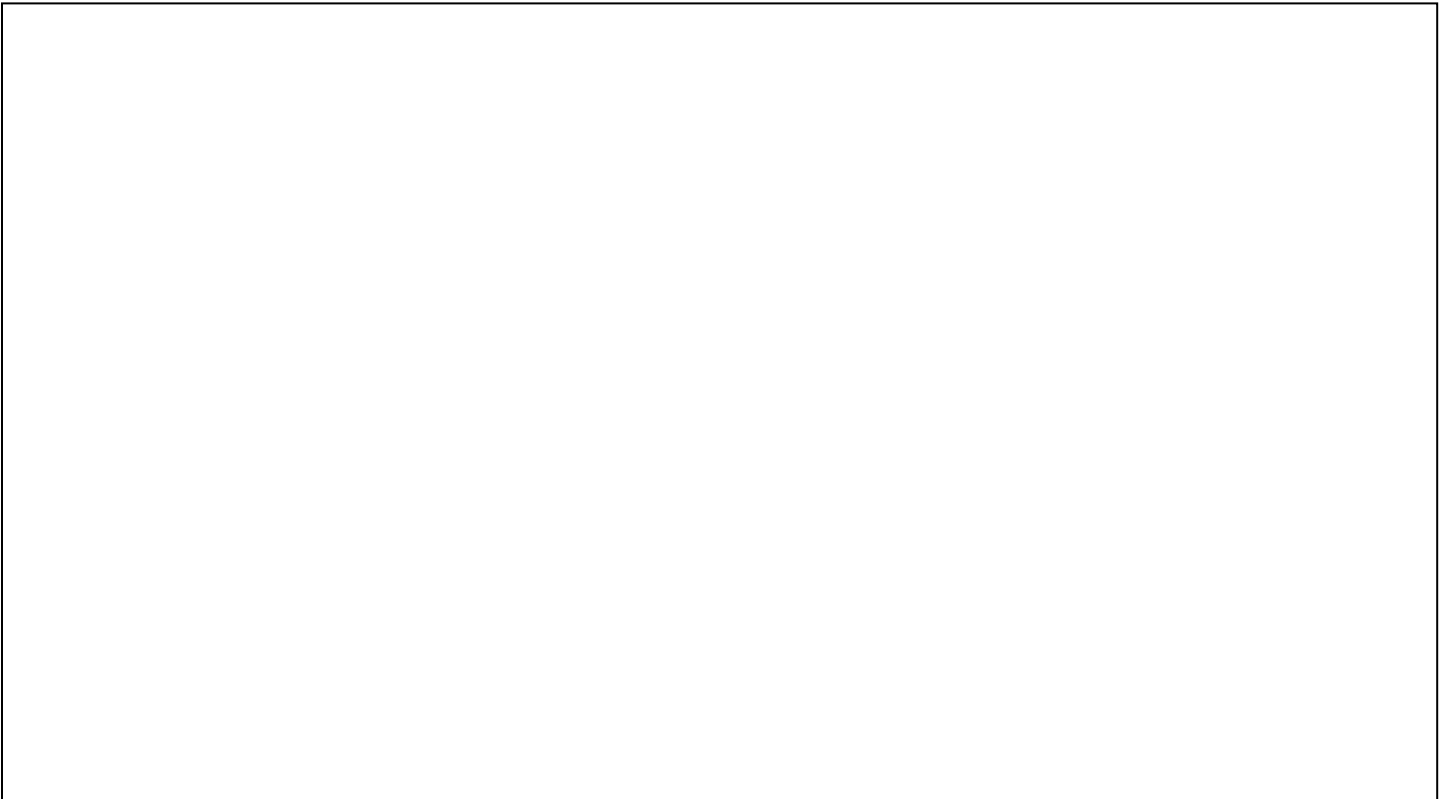
Have you been diagnosed by a licensed medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or ever tested positive for Human Immunodeficiency Virus (HIV)? Yes No

Family History:

Have you or your immediate family members (parents, brothers, sisters) dies of or been diagnosed as having coronary artery disease, stroke, diabetes, cancer, polycystic kidney disease or Huntington's disease prior to age 60? Yes No

Any family history we should document:

Explanation:

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