Part I

Date:_______________

Client:______________________/______________________
Primary Other Insured

DOB:____________/_____________ Married: Y/N

Address:____

Home#______________ Work#___________/____________

Cell #____________/_______________

Email:________________/____________________

Occupation:__________________/___________________

Beneficiary:__________________/___________________

Part II

SS#__________/__________ Dl#__________/__________

Children Names w/DOB:________________________________

____

____

Who else do you know that I could help protect their family?_________

____

____

Do you know anybody that would like to make $2000/ month part time?

____

____

Do you have any money in mutual funds, cds, or an old 401k?________

____

Special processing comments:_________________________

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OFFICE USE ONLY

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

	Primary Insured	Other Insured
1. Are you a citizen of the United States? If "No", what is your citizenship? Immigration status? Type of visa?	OY ON	OY ON
2. Have you traveled or resided outside the United States or Canada within the past 2 years or plan to do so within the next 2 years?	OY ON	OY ON
3. Have you been convicted of a felony or are currently on parole for any offense?	OY ON	OY ON
4. In the past 10 years have you been convicted of DWI/DUI? In the past 5 years have you had any speeding tickets or other driving violations?	OY ON	OY ON
5. In the past 5 years have you participated in ballooning, bungee jumping, cliff diving, hang gliding, motorized racing, parachuting, mountain or rock climbing, skin or scuba diving, or any similar avocation?	OY ON	OY ON
6. In the past 5 years have you flown as a pilot, student pilot, or crew member of an aircraft?	OY ON	OY ON
7. In the past 10 years have you ever sought or received treatment, advice, or counseling for the use of alcohol?	OY ON	OY ON
8. Have you ever sought or received treatment, advice, or counseling for the use of any narcotic, barbiturate, stimulant, amphetamine, hallucinogenic, street, or prescription drugs? Have you ever been arrested for the use or possession of such drug or are you currently using these drugs?	OY ON	OY ON
9. Within the past 10 years have you made a claim or received benefits for disability or worker's compensation as a result of a sickness or injury?	OY ON	OY ON
10. Within the past 7 years, have you filed for bankruptcy?	OY ON	OY ON
11. *(Only required when applying for HomeCertain term insurance)* In the past 13 months have you contracted for a home mortgage, or refinanced an existing mortgage? If the answer is yes, please list the amount of the mortgage or refinancing, and the name and address of the lending institution.	OY ON	OY ON

1. Have you ever been treated for or diagnosed with:		
a) Any heart disease, heart attack, chest pain, high blood pressure, high cholesterol, murmur, palpitations, or any other disorder of the heart or blood vessels?	OY ON	OY ON
b) Any circulatory disease, stroke, TIA, aneurysm, or any other disorder of the veins or arteries?	OY ON	OY ON
c) Any breathing or lung disorders, COPD, asthma, bronchitis, sleep apnea, or emphysema?	OY ON	OY ON
d) Diabetes, disorder of the immune system, blood disorder, or disorder of the glands?	OY ON	OY ON
e) Cancer, tumor, or cyst?	OY ON	OY ON
f) Depression, anxiety, dementia, Alzheimer's, or any other mental or nervous disease or disorder?	OY ON	OY ON
g) Hepatitis, gastritis, colitis, or any disease or disorder of the liver, stomach, pancreas, or intestines?	OY ON	OY ON
h) Any disease or disorder of the kidneys, bladder, prostate, urinary, or reproductive systems?	OY ON	OY ON
i) Arthritis or any disease or disorder of the muscles (to include strains or sprains), tendons, bones, spine, back, or joints?	OY ON	OY ON
j) Any disease or disorder of the skin, eyes, or ears?	OY ON	OY ON
k) Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive test results indicating the presence of the AIDS virus?	OY ON	OY ON
2. Are you currently prescribed any medication?	OY ON	OY ON
3. Have you been prescribed medication in the past 5 years not previously mentioned?	OY ON	OY ON
4. In the past 10 years, have you:		
a) Been hospitalized or had surgery?	OY ON	OY ON
b) Had any electrocardiograms, x-rays, laboratory tests, treatments, or procedures?	OY ON	OY ON
c) Been recommended to have any test, treatment, or surgery which has not been performed?	OY ON	OY ON
d) Had any illness, disease, or injury that is not included in other answers?	OY ON	OY ON
5. Has any parent, brother, or sister died from or had any occurrence of cancer, heart disease, diabetes, or any hereditary disease prior to age 60?	OY ON	OY ON
6. Have you smoked cigarettes, pipes, or cigars, used snuff, chewed tobacco, or used any nicotine based product such as patch or gum? If yes, please detail the type(s) of tobacco product used and date of last use below.	OY ON	OY ON

1. Precise medical term, if known?
2. Date and duration of attack or episode?
3. Diagnostic tests – names of tests and symptomatology along with test results?
4. If a chronic or recurrent condition, determine date of first attack, frequency or episodes, and date of last attack?
5. Residuals, after effects and complications, if any?
6. Nature of treatment, including surgery, or medication and date of last such treatment or medication? If surgery was performed, what were the results and pathology report?
7. Hospitalizations – date, reason, length of stay, name and location of hospital?
8. Any follow-up treatment recommended or planned?
9. Full names and addresses of physicians and the dates seen (month and year, month is especially important if within the past two years)
10. If more than one doctor has been consulted for a specific condition, please state the sequence in which the doctors were seen. Did one doctor recommend the other, etc.? Please indicate which doctor would have the necessary information.

Disability Income Rider

1. Please indicate full occupational duties, title, nature of business, and annual income. If applicant is self-employed – need gross income as well as net income after taxes.
2. Please indicate disability income rider class and monthly payout on the application.
3. Please indicate the elimination period on the application.
4. Please indicate if applicant has any disability income in-force with Fidelity and Guaranty Life Insurance or any other companies – we need to know total amount of Disability Insurance coverage in-force with all companies.
5. Need full details to all YES answers on the application.
6. Please be aware that the conditional receipt provides no insurance for riders or additional benefits.
7. The underwriter will be paying special attention to the following areas:
1. Occupation 5. Pregnancy
2. Mental/Nervous disorders 6. Diabetes
3. Back pain history 7. Hypertension
4. Arthritis