



LifePro™ Trial Application

PERSONAL INFORMATION	PROPOSED INSURED 1	PROPOSED INSURED 2 (If applicable)
Full Name		
Address		
Phone Number	()	()
Date of Birth	/ /	/ /
Male / Female	___ Male ___ Female	___ Male ___ Female
Social Security Number	- -	- -
Driver's License / State		
Occupation		
Do you smoke?	___ Yes, what and how much? _____ ___ No, never smoked ___ No, but quit _____	___ Yes, what and how much? _____ ___ No, never smoked ___ No, but quit _____
Height / Weight	___ Ft. ___ In. _____ Lbs.	___ Ft. ___ In. _____ Lbs.
Name, address and phone number of personal or attending physician		
	()	()
Medications you currently take		

HEALTH QUESTIONNAIRE					
So far as you know, within the past 10 years have you ever had?		Insured 1		Insured 2	
		Yes	No	Yes	No
a	Chest pain, shortness of breath, heart murmur, high blood pressure, stroke, irregular heart beat, or other disease or disorder of the heart or arteries?				
b	Diabetes or disease of any gland?				
c	Mental or emotional disorder, nervous breakdown, convulsions, epilepsy, paralysis or any other disorder of the brain or nervous system?				
d	Arthritis, gout, or any bone, joint, muscle or skin disorder?				
e	Asthma, bronchitis, pneumonia, emphysema, or any lung disorder?				
f	Cirrhosis, hepatitis, ulcer, colitis, diverticulitis or any disorder of the liver or intestines?				
g	Prostate or testicular disease, disease of the uterus, ovaries or breasts?				
h	Anemia, leukemia, clotting disorders, platelet disorders, infections or sources of blood loss?				

HEALTH QUESTIONNAIRE

So far as you know, within the past 10 years have you ever had?		Insured 1		Insured 2	
		Yes	No	Yes	No
i	Cancer or tumors?				
j	An operation or admission to a health care facility, for observation, treatment of any illness or diagnostic tests, including treadmill stress test for insurance?				
k	Disorder of the urinary tract or kidneys, sugar, albumin or blood in the urine?				
l	Any other health impairment or medically treated condition?				
m	Use of narcotics, amphetamines, cocaine or any prescription drug except in accordance with physician's instructions?				
n	Treatment for alcohol or drug use of been advised to have such treatment by a doctor, licensed practitioner or any organization?				
o	A positive test result for exposure to the HIV infection, or been diagnosed as having ARC or AIDS or other sickness derived from such infection?				
p	Have you been admitted to a medical facility in the last two years?				
q	Is there a family history of cancer, diabetes, heart disease, or has either parent died prior to age 60?				
r	In the last two years, have you been unable to work or been disabled for one month or more?				
s	Have you ever engaged in any type of flying as a pilot or crew member; skin, scuba, or sky diving; auto or boat racing; or any intention of doing so?				
t	Do you have any intention of traveling or residing outside the United States or Canada during the next two years?				
u	Has any application for insurance been declined, rated, modified or postponed?				
v	Do you have any life insurance currently in force, or will be replacing? (Please also disclose if you have any policy loans or plan to take a policy loan to fund the new insurance?				

DETAILS FOR "YES" ANSWERS TO HEALTH QUESTIONS

PROPOSED INSURED 1

Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone# of Attending Doctor / Hospital

DETAILS FOR "YES" ANSWERS TO HEALTH QUESTIONS
PROPOSED INSURED 2

Q#	Date(s)	Reason & Treatment	Duration	Name, Address & Phone# of Attending Doctor / Hospital

FINANCIAL INFORMATION

Income Information

Salary	\$	Living Expenses	\$
Company Pension	\$	Taxes (State & Federal)	\$
Social Security	\$	Gifts to Family	\$
Investment Income	\$	Other	\$
IRA Distribution	\$	Federal Income Tax Bracket	
Total Income	\$	State Income Tax Bracket	

Financial Information (Attach a financial statement if available)

Assets	Market Value	Cost Basis	Growth Assumption		
Primary Home	\$	\$	%	Total Assets	\$ _____
Secondary Home	\$	\$	%		
Real Estate	\$	\$	%	Less Liabilities	\$ _____
Business	\$	\$	%		
Stocks	\$	\$	%	Net Worth	\$ _____
Mutual Funds	\$	\$	%		
Annuities	\$	\$	%	Plus Personally	
Tax Free Bonds	\$	\$	%	Owned Life Insurance	\$ _____
Money Markets	\$	\$	%		
Retirement Plans	\$	\$	%	Taxable Estate	\$ _____
Notes Receivable	\$	\$	%		
Other	\$	\$	%		

Do you anticipate any inheritances? No Yes, estimated amount: \$ _____

REQUESTED PLAN OF INSURANCE

Type of Insurance Desired:	<input type="checkbox"/> Universal Health <input type="checkbox"/> Whole Life <input type="checkbox"/> Term <input type="checkbox"/> Survivorship <input type="checkbox"/> Variable <input type="checkbox"/> Other: _____
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Insurance currently pending or applied for with all carriers:

Carrier	Amount	Type	Status

Total Death Benefit to be Placed	\$ _____
Desired Premium	\$ _____
Additional Dump In	\$ _____
Source of Funds	_____

CONCEPT INFORMATION PURPOSE OF THE INSURANCE

Personal	Business
<input type="checkbox"/> Estate Planning <input type="checkbox"/> Charitable Contribution <input type="checkbox"/> Wealth Replacement <input type="checkbox"/> Income Replacement <input type="checkbox"/> Loan Securement Amount of Loan: \$ _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> Buy / Sell <input type="checkbox"/> Key person <input type="checkbox"/> Business Continuation <input type="checkbox"/> Loan Securement Amount of Loan: \$ _____ <input type="checkbox"/> Other: _____ Business Ownership %: _____ Gross Sales / Revenue: \$ _____ Expenses: \$ _____ Book Value of Company: \$ _____

How was the amount of insurance calculated?

AGENT INFORMATION

Agent Name	_____
Agent Contact	_____
Address	_____ _____
Phone Number	() _____
Fax Number	() _____
E-Mail Address	_____
Social Security Number	_____

