



**Life Insurance**

(Select one)

- Quote Request**
- Application**

**\*All items with an asterisk are required.**

**Client Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ Male  Female

**SSN:** \_\_\_\_\_ **Client Phone #:** \_\_\_\_\_  
Main # Secondary #

**United States Citizen?** Yes  No  If no, citizen of which country: \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street Address City State Zip

**\*Beneficiary Name:** \_\_\_\_\_ **\*Relationship:** \_\_\_\_\_

**\*DOB:** \_\_\_\_\_ **\*SSN:** \_\_\_\_\_

**\*Address:** \_\_\_\_\_  
Street Address City State Zip

**\*Email Address:** \_\_\_\_\_

**Carrier:** \_\_\_\_\_ **Face Amount \$** \_\_\_\_\_ **Length of term** \_\_\_\_\_ years

**\*Has the proposed insured ever used tobacco in any form?** Yes  No  What Type: \_\_\_\_\_

Last used: 12 months  36 months  5 years  More:  \_\_\_\_\_ years

**\*Current Height:** \_\_\_\_\_ Feet \_\_\_\_\_ Inches **Current Weight:** \_\_\_\_\_ Lbs.

**\*Current Occupation:** \_\_\_\_\_

**Does the proposed insured participate in piloting an aircraft, scuba diving, motor vehicle racing, etc.?**

No  Yes  If yes, provide details: \_\_\_\_\_

**Has proposed insured traveled out of the US in the past 12 months or plan to in the next 12 months?**

No  Yes  If yes, provide details: City \_\_\_\_\_ Country \_\_\_\_\_

Reason for travel \_\_\_\_\_ Length of stay \_\_\_\_\_

**Is proposed insured taking any prescription medications?**

No  Yes  If yes, detail \_\_\_\_\_

**Does the proposed insured consume alcoholic beverages?**

No  Yes  If yes, provide how often and what type \_\_\_\_\_

**Does the proposed insured have a history of alcohol or substance abuse?**

No  Yes  If yes detail: \_\_\_\_\_

**Do the proposed insured have any DWI or DUI convictions in the past?**

No  Yes  If yes, date(s) \_\_\_\_\_

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**Has the proposed insured had more than 2 motor vehicle moving violations in the past 3 years?**

No  Yes  \*DL#: \_\_\_\_\_ \*State: \_\_\_\_\_

**Has either parent or sibling had a history of cardiovascular disease or cancer before age 60:**

No  Yes  If yes, detail: \_\_\_\_\_

**\*Currently any Life Insurance inforce?** No  Yes

**\*If yes, Carrier:** \_\_\_\_\_ **Face Amount\$** \_\_\_\_\_

**Issue Date:** \_\_\_\_\_ **Policy #:** \_\_\_\_\_

**\*Will this policy be a replacement of any current coverage?** No  Yes

**Will the insured (you) be the owner of this policy?** No  Yes

If No, the owner of this policy will be: \_\_\_\_\_

Relationship to the insured is: \_\_\_\_\_

Owner's Social Security Number: \_\_\_\_\_

Or Tax ID Number \_\_\_\_\_

Owner's Address: \_\_\_\_\_

Owner's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of authorized signor: \_\_\_\_\_

**What is the purpose of the insurance?**

**Personal** (family protection, income replacement, estate planning)

\*Gross annual income of the client: \_\_\_\_\_ \*Household Income: \_\_\_\_\_

\*Net Worth: \_\_\_\_\_

**Business** (buy/sell business, key person business)

\*Total Assets: \_\_\_\_\_

\*Liabilities and Net Worth of the company: \_\_\_\_\_

\*%of client ownership , if any: \_\_\_\_\_

\*Gross annual salary of client: \_\_\_\_\_

\*Any applied for or inforce on other key members of the business? No  Yes

**Agent name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Agent email address:** \_\_\_\_\_

**PLEASE NOTE:** Completing this form does not constitute any coverage. Coverage will not begin until underwriting is complete and accepted.

Email completed form to:

[JoeZ@Whortonins.com](mailto:JoeZ@Whortonins.com) OR [CherieR@Whortonins.com](mailto:CherieR@Whortonins.com)

**Whorton Insurance Services | 800.945.1191 | Whortonins.com**

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