Life Insurance

(Select one)

☐ **Quote Request**
☐ **Application**

Email completed form to: HealthPlans@whortonins.com or fax to 512-338-1196

***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) _____

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.

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