

Applicant's name _____ Resident state _____ Date of Birth ____/____/____

Job duties _____

W2 employee or self-employed? _____ If W2 employee, list monthly income \$ _____

If self-employed:

For how long? _____ What percentage of the company do you own? _____

How many employees are employed by the business? _____

Do you work out of your home? ☐ Yes ☐ No

Taxable earned income for this year \$ _____ Last year \$ _____

Height ____ ft. ____ in. Weight _____ ☐ Male ☐ Female

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ☐ Yes ☐ No

If YES, please list type _____ amount per day _____ last date of use ____/____/____

Medications _____

Back and/or neck problems? ☐ Yes ☐ No Chiropractic treatment? ☐ Yes ☐ No Last date seen ____/____/____

Diabetes? ☐ Yes ☐ No ☐ Type I ☐ Type II Age at onset _____

Hypertension? ☐ Yes ☐ No Date of diagnosis ____/____/____ Last reading _____, date ____/____/____

Skin cancer or tumors? ☐ Yes ☐ No Type and location _____ Last treatment date ____/____/____

Drug and/or alcohol abuse? ☐ Yes ☐ No Type of drug _____ Amount of alcohol _____

Treatment dates _____ Involvement in support groups ☐ Yes ☐ No Which? _____

Other medical history:

Agent Name _____

Agent Email _____

Agent Phone _____

Please Circle Options Below

Benefit Period : 2yr 5yr 10yr Age 65 Age 67

Elimination Period : 60 90 180 365 days

Riders : Own Occ COLA Future Purchase Non-Can