

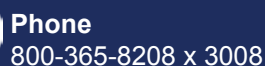
with Premier
Life & Annuities, LLC

Attention (please circle one): Kathy Elkins Kelly Rardon Melissa Hof f art

Number of Pages: _____ (no need to send blank pages)

When needed by:

Message:

[illegible]

Agent Information

Agent Name: _____

Agent Phone Number: _____

Proposed Policy

Amount of Insurance: _____

Type of Plan:

- ☐ Universal until age _____
- ☐ Whole Life
- ☐ Term - Desired Length _____
- ☐ Single Pay

Main Objective:

(circle one from each)

Death Benefit or Cash Value

Express Issue or Fully Underwritten

Riders:

- ☐ Return of Premium
- ☐ Waiver of Premium
- ☐ Child Rider - desired amount _____
- ☐ LTC
- ☐ Accident - desired amount _____
- ☐ Other _____

Replacing Policy?

☐ Yes

☐ No

If yes, do they have cash value? _____

Client Information

Client's Name: _____

State: _____

Male ☐ Female ☐

DOB: ____/____/____ Height: _____ Weight: _____

(If weight has changed more than 15 lbs in the last year, list amount of weight gained or lost and the cause) _____

Blood Pressure Reading: _____

Cholesterol Reading: _____

HDL Ratio: _____

Tobacco User: Yes ☐ No ☐

If so, please indicate the type used and frequency. If quit, indicate last use.

Family History

Is there a history of heart disease or cancer in your immediate family?

	Age of Living	Age at Death	Heart Disease or Cancer History	Cause of Death
Father				
Mother				
Siblings				

Medical Questions (Please explain all "Yes" answers in the additional information section)

Have you ever had, been treated for, or been medically advised to be treated for, any of the following?

	Yes	No	Comments:		Yes	No	Comments:
Alcoholism	<input type="radio"/>	<input type="radio"/>		High Blood Pressure	<input type="radio"/>	<input type="radio"/>	
Angina	<input type="radio"/>	<input type="radio"/>		High Cholesterol	<input type="radio"/>	<input type="radio"/>	
Anxiety	<input type="radio"/>	<input type="radio"/>		HIV/AIDS	<input type="radio"/>	<input type="radio"/>	
Arthritis	<input type="radio"/>	<input type="radio"/>		Irregular Heartbeat	<input type="radio"/>	<input type="radio"/>	
Asthma	<input type="radio"/>	<input type="radio"/>		Kidney Disorder	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>		Lupus	<input type="radio"/>	<input type="radio"/>	
Chronic Pain	<input type="radio"/>	<input type="radio"/>		Mental Illness	<input type="radio"/>	<input type="radio"/>	
Cirrhosis	<input type="radio"/>	<input type="radio"/>		Migraines	<input type="radio"/>	<input type="radio"/>	
Colitis	<input type="radio"/>	<input type="radio"/>		Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	
COPD	<input type="radio"/>	<input type="radio"/>		Pacemaker	<input type="radio"/>	<input type="radio"/>	
Depression	<input type="radio"/>	<input type="radio"/>		Paralysis	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>		Parkinson's Disease	<input type="radio"/>	<input type="radio"/>	
Drug Use/Abuse	<input type="radio"/>	<input type="radio"/>		Pregnant (currently)	<input type="radio"/>	<input type="radio"/>	
Epilepsy	<input type="radio"/>	<input type="radio"/>		Prostate Disorder	<input type="radio"/>	<input type="radio"/>	
Heart Attack	<input type="radio"/>	<input type="radio"/>		Sleep Apnea	<input type="radio"/>	<input type="radio"/>	
Heart Disease	<input type="radio"/>	<input type="radio"/>		Stroke or TIA	<input type="radio"/>	<input type="radio"/>	
Hepatitis	<input type="radio"/>	<input type="radio"/>		Thyroid Disorder	<input type="radio"/>	<input type="radio"/>	

Medications

Record all medications you currently take including **prescription medications** and any **over the counter drugs**.

Name of Drug	Dosage	Frequency	When Prescribed	Reason for Taking

Cancer History

Type: _____
Date Diagnosed: _____
Treatment: _____

Stage: _____
Grade: _____
Lymph Node Involvement: ☐ Yes ☐ No
Date of Last Treatment: _____
Any Recurrence? ☐ Yes ☐ No
If prostate cancer, please include pre-PSA: _____
current PSA: _____
Gleason Score: _____

Diabetes History

☐ Type I ☐ Type II
Date Diagnosed: _____
A1C: _____
Any Complications (retinopathy, neuropathy, nephropathy): _____

Heart Disease History

Heart Attack: ☐ Yes ☐ No
If yes, please provide date(s): _____

Stroke: ☐ Yes ☐ No
If yes, please provide date(s): _____

TIA: ☐ Yes ☐ No
If yes, please provide date(s): _____

Bypass Surgery? ☐ Yes ☐ No # of Vessels: _____
Which Vessels? _____

% of Blockage: _____
Angioplasty? ☐ Yes ☐ No # of Vessels: _____
Which Vessels? _____

% of Blockage: _____

Mental Illness/Depression History

Name of condition: _____
Date Diagnosed: _____
Severity: _____
Treatment: _____

Seeing a psychiatrist/psychologist? _____
Attempted suicide? If yes, date(s): _____

Lung Disorder History

Type of Disorder (asthma, bronchitis, COPD, emphysema, etc.): _____

Treatment: _____
Severity: _____
Frequency of attacks: _____
Dates of hospitalizations/ER visits: _____

MVR/Recreational Hobbies/Hazardous Occupation

Record all **driving infractions** for the past 10 years

Type	Yes/No	Date(s) of Ticket(s)	Explanation of Penalty (<i>Fines, Community Service, Probation, Jail Time, Etc.</i>)	Loss or Suspension of License
Speeding Tickets				
DWI/DUI				
Tickets (Reckless Driving, Etc.)				

Record any **dangerous recreational hobbies**.

Type (Sky Diving, Climbing, Motor Sports, Flying)	Description of Activity

Record any current **hazardous occupation**.

Occupation	Description of Job

Criminal Activity

Record all charges for **criminal activity**.

Offense	Date of Offense	Misdemeanor or Felony	Explanation of Penalty	Probation End Date

Additional Information

Please include any Health History that was not covered in above areas. Also, include any additional information that you may have regarding the above areas. If this is a rush, please indicate when needed by. For certain risk assessments, we are at the mercy of the carriers to get back to us. Please allow extra time so we can find you the best carrier given the information provided.

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

Submitting an effective cover letter with the application can go a long way in the underwriting process. It can speed up the process and possibly avoid a quick decline. Provide financial, medical, and lifestyle details to give the underwriter a more accurate portrait of your client.