Mortgage Protection

Client Information

Name: Contact#:

Address:

City: State: Zip:

How long at current address? ***(If less than 5 years, prior address is required)***

Previous Address:

City: State: Zip:

E-mail: SS#

Weight: Height: DOB:

Are you a US Citizen? YES NO Are you employed? YES NO

Sex: ***(Highlight one)*** Male Female

Marital Status: ***(Highlight one)*** Single Married

If Yes, Employer Name:

Occupation: Annual Salary:

Description of Job Duties:

Product Information

What Term are you interested in? ***(Highlight one)*** 10-Year Term 15-Year Term

20-Year Term 25-Year Term 30-Year Term

Do you want to add additional Riders? ***(Highlight all that apply)*** Suggested Face Amount: $

Cash Back Rider Children's Term Rider Additional Insured Term Insurance

Disability Income Rider Waiver of Premium Critical Illness Accelerated

Health Information

1. Are you a Smoker? ***(If yes, list how many times)*** YES NO

Daily: Weekly: Monthly:

2. Have you ever been:

Mortgage Protection - Continues

A. Diagnosed or tested positive for AIDS or Acquired Immune Deficiency Syndrome? YES NO

B. Diagnosed or treated for specified symptoms such as immune deficiency, recurrent fever, unexplained weight loss, fever of unknown origin, severe night sweats, unexplained infections or skin lesions, unexplained swelling of the lymph glands, Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia? YES NO

3. Have you ever been diagnosed with, or received care of treatment, or been advised by a medical profession to seek treatment for, or consulted with a health care provider regarding:

A. Coronary Artery Disease, Heart Attack, Coronary Artery Bypass Surgery, Angioplasty, Stent Placement, Valvular Heart Disease, Cardiomyopathy, Congestive Heart Failure, Congenital Heart Disease, Stroke, Transient Ischemic Attack (TIA) Mini Stroke, abnormal heart rhythm, Cerebral, Aortic or Thoracic Aneurysm or Abdominal Aortic Aneurysm? YES NO

B. Chronic Lung Disease (except Asthma), including Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis, Emphysema, Sarcoidosis, or Cystic Fibrosis? YES NO

C. Major Depression, Bipolar Depression, Schizophrenia, Alzheimer's Disease, Dementia, Down Syndrome, Autism, mental incapacity, suicide attempt, or any other disease of the central nervous system? YES NO

D. Chronic Kidney Disease, End-Stage Renal Disease, Renal Insufficiency, or any condition within the last 5 years that required dialysis? YES NO

E. Parkinson's disease, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), Muscular Dystrophy, Demyelinating Disease including Multiple Sclerosis, Huntington's Disease, Hydrocephalus, Quadriplegia, or Paraplegia? YES NO

F. Do you have any of the following: ***(Highlight all that Apply)*** YES NO
Crohn's Disease, Ulcerative Colitis, Hepatitis B, Cirrhosis or Liver Disease

G. Cancer, Leukemia, Melanoma, any tumor (benign or malignant) of the brain, or any other cancer ***(except basal cell cancer)***? YES NO

H. Rheumatoid Arthritis, Systemic Lupus, or Scleroderma? YES NO

I. An organ Transplant? YES NO

J. Diabetes requiring insulin in any form or with complications such as Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve), or Peripheral Vascular Disease (PVD or PAD)? YES NO

4. Do you currently have a primary care physician? ***(If yes, list info below)*** YES NO

Mortgage Protection - Continues

Doctor's Name: Contact: Last App Date:

Address:

City: State: Zip:

5. Have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a medical profession to seek treatment for Diabetes? ***(If yes, list info below)*** YES NO

A. What was the original diagnosis date?

B. Is physician different that your primary care physician? ***(If yes, list info below)*** YES NO

Doctor's Name: Contact: Last App Date:

Address:

City: State: Zip:

C. Are you being treated with prescription(s) for Diabetes? ***(If yes, list all info)*** YES NO

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

D. What was your most recent fasting blood sugar reading or A1c and the date it was recorded? Date:

6. Have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a medical profession to seek treatment for Hypertension ***(High Blood Pressure)***? ***(If yes, list info below)*** YES NO

A. What was the original diagnosis date?

B. Is physician different that your primary care physician? ***(If yes, list info below)*** YES NO

Doctor's Name: Contact: Last App Date:

Address:

City: State: Zip:

C. Are you being treated with prescription(s) for Hypertension? ***(If yes, list all info)*** YES NO

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

D. What was the most recent blood pressure reading and the date it was recorded?

Systolic: Diastolic: Date:

Mortgage Protection - Continues

7. In the past 5 years, have you had or been advised by a medical profession to have an echocardiogram, stress test, or cardiology or nephrology consultation due to symptoms? ***(If yes, list info below)*** YES NO

Test/Consultation Date: Results:

Doctor's Name: Contact: Last App Date:

Address:

City: State: Zip:

8. In the past 5 years, have you ever (1) been diagnosed with, or (2) received care or treatment for, or (3) been advised by a medical profession to seek treatment for Epilepsy or Seizure Disorder? ***(If yes, list info below)*** YES NO

A. What was the original diagnosis date?

B. Is physician different than your primary care physician? ***(If yes, list info below)*** YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

9. In the past 5 years, have you ever (1) been diagnosed with, or (2) received care or treatment, or (3) been advised by a medical profession to seek treatment for, or (4) consulted with a health care provider regarding: YES NO

A. Mild or Situational Depression or Anxiety? ***(If yes, list info below)*** YES NO

i. What was the original diagnosis date?

ii. Is the physician different than your primary care physician? YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

iii Has this condition:

(a) Required treatment with prescription(s) for Mild Depression or Anxiety? ***(If yes, list info)*** YES NO

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Mortgage Protection - Continues

(b) Required in-patient hospitalization? ***(If yes, provide date)*** YES NO

(c) Caused inability to work due? ***(If yes, provide date)*** YES NO

B. Asthma? ***(If yes, complete questions below)*** YES NO

i. What was the original diagnosis date?

ii. Is the physician different than your primary care physician? YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

iii Does this condition:

(a) Require daily medication to control Asthma? ***(If yes, list info)*** YES NO

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

(b) Require steroid medication for Asthma? ***(If yes, list info)*** YES NO

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

Rx: Dosage: Frequency:

iv Has this condition required hospitalization or Emergency Department visits? ***(If yes, provide date)*** YES NO

C. Sleep Apnea? ***(If yes, complete questions below)*** YES NO

i. What was the original diagnosis date?

ii. Is the physician different than your primary care physician? YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

iii Do you use CPAP or BIPAP for treatment of sleep apnea nightly, or as prescribed by your physician? YES NO

Mortgage Protection - Continues

iv Have you been advised by a medical profession that your treatment has been successful in controlling your symptoms? YES NO

D. Psoriatic or other Inflammatory Arthritis? ***(If yes, complete questions below)*** YES NO

i. What was the original diagnosis date?

ii. Is the physician different than your primary care physician? YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

iii How many joints are involved?

E. Any disease or disorder of the Bones or Muscles? ***(If yes, complete questions below)*** YES NO

i. What was the original diagnosis date?

ii. Is the physician different than your primary care physician? YES NO

Name: Contact: Last App Date:

Address:

City: State: Zip:

iii Have you had surgery for any disorder of your bones or muscles? YES NO
(If yes, provide date & muscle or bone impacted)

Date: Muscle: Bone:

If yes, have you been released by your physician to return to normal activities and have all necessary follow-ups been completed? YES NO

10. In the past 12 months, have you been prescribed or have you taken prescription pain medication? ***(If yes, list prescription details below)*** YES NO

Rx: Dosage: Date: Frequency: Reason:

Rx: Dosage: Date: Frequency: Reason:

Rx: Dosage: Date: Frequency: Reason:

11. In the past 12 months, other than for wellness visits, minor injuries, or illnesses for which a medical professional has deemed you fully recovered and requiring no further treatment or follow-up, have you consulted any member of the medical profession not already identified for any reason? ***(If yes, complete Medical History Details below)*** YES NO

Mortgage Protection - Continues

12. Are you, at the time of this application, confined to any hospital or other medical facility? ***(If yes, complete Medical History Details below)*** YES ______ NO ______

13. In the past 12 months, have you had or had recommended by a medical profession, but not yet completed, any surgery, treatment or hospitalization? ***(If yes, complete the Medical History Details below)*** YES ______ NO ______

Medical History Details

Please provide details of all **"Yes"** answers to questions 11, 12 and 13 in the area below. ***(Attach an Application Addendum if more space is needed in order to avoid amendments)***

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Information of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Contact:		
Details, including medications prescribed and results of last visit:					

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Information of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Contact:		
Details, including medications prescribed and results of last visit:					

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Information of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Contact:		
Details, including medications prescribed and results of last visit:					

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Information of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Contact:		
Details, including medications prescribed and results of last visit:					

Question #	Date of Diagnosis or Onset of Treatment	Medical Diagnosis	Information of Attending Physician or Medical Facility		Date of Last Visit
			Name:		
			Address:		
			Contact:		
Details, including medications prescribed and results of last visit:					

Mortgage Protection - Continues

Personal History Information

Provide details of all "**Yes**" answers in the Personal History Details section below.

14. Have you ever been declined, rated or modified for life or health insurance? YES NO

15. Have you currently, or within the last 12 months, used any of the following: walker, wheelchair, electric scooter, oxygen, or catheter? YES NO

16. Within the past 2 years, have you made any flights as a pilot or student pilot? YES NO

17. In the next 2 years, do you intend to engage in any motor sports racings, boat racing, parachuting/skydiving, hang gliding, base jumping, rock or mountain climbing, cave diving, underwater photography, canyoning, or Scuba Diving over 100ft? YES NO

18. Within the past 10 years, have you been convicted of, or are you currently awaiting trial for, any felony? YES NO

19. Are you currently on or have you been released from probation, parole, or other court ordered supervision with the laws 2 years? YES NO

20. Within the next 2 years, do you intend to work, travel or reside outside of the United States for more than 30 days? YES NO

21. In the past 10 years, have you:

A. Used heroin, morphine, other narcotics, ecstasy, opium derivatives, marijuana, cocaine, crack, barbiturates, amphetamines, methamphetamines, or hallucinogens or any other illegal, restricted or controlled substances; or been treated or been advised by a member of the medical profession to seek treatment for the intake of any drug? YES NO

B. Used alcohol to a degree that required treatment or been advised to limit or discontinue its use by a medical profession? YES NO

C. Used or been convicted of possession of unlawful drugs or used prescription drugs other than as prescribed in any form? YES NO

22. Do you currently hold a valid driver's license? ***(If yes, provide info below)*** YES NO

Name on Driver's License	Driver's License Number	State Issued

23. Within the past 5 years, have you been convicted, pled guilty, or entered into a plea agreement for driving under the influence of drugs or alcohol or reckless driving, or had 3 or more moving violations or had your driver's license suspended or revoked? ***(If yes, provide license info if different above & provide details of Yes answer under Personal History Details below)*** YES NO

Mortgage Protection - Continues

Name on Driver's License	Driver's License Number	State Issued

Personal History Details

Please provide details of all "**Yes**" answers to questions 14 through 23 in the area below.

Question #	Date	Details

Mortgage Protection - Continues

Previous Quote Information

Previous Policy Quote Given: _____ Monthly Lock Amount: _____

Refinance Option Information

Do you want to: ***(Highlight only one)***

Refi Rate & Term	Refi / Cash Out	Not At This Time

Beneficiary's Information

Name: _____ Contact#: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ SS# _____

Date of birth: _____ Relationship: _____

Life Insurance In Force And Replacement Information

Do you already have Life Insurance applications pending with other companies? YES NO

(If yes, provide info below)

Insurance Type	Face Amount	Company	Paramed Exam/Fluids Required?			App Signed Date
			Yes		No	
			Yes		No	
			Yes		No	
			Yes		No	

Do you have any existing Life Insurance or Annuity Coverage now? YES NO

(If yes, provide info below)

Company	Date	Accidental Death Benefit	Will New Insurance Replace Old?		Face Amount
				Internal External Replacement	

				Internal External Replacement	

Mortgage Protection - Continues

Owner's names of each insurance policies if different than the Insured: ***(In the order as it appears above)***

Owner's names of each Annuity policies if different than the Insured: ***(In the order as it appears above)***

Today Lock In Rate - Payment Information

Bank Name:

City: State: Zip:

Routing Number: Account Number:

Account Type: ***(Highlight only one)*** Checking Savings

Name on Account: Specific Draft Start Date: /
Month Day

VOID

Insured's Signature: *Date:*

Owner's Signature (If different than Insured): *Date:*