

APPLICATION

PERSONAL DATA

Today's Date: _____

Insured's Name: _____
Date of Birth: _____ Gender: _____
Social Security #: _____

Joint Insured: _____
Date of Birth: _____ Gender: _____
Social Security #: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Martial Status: _____ Dependent Children: Y N

LIFE INSURANCE POLICY

Bankruptcy: Y N

Policy Issue Date: _____ Death Benefit: _____ Premium Amount: _____

Insurance Company: _____ Mode: _____

Policy #: _____ Type of Insurance: _____ Cash Value: _____

Beneficiary: _____

Address: _____ City: _____ State: _____ ZIP: _____

Owner: _____

Address: _____ City: _____ State: _____ ZIP: _____

TAX ID # _____

MEDICAL HISTORY

(Please include all doctors for past 5 years – use separate sheet if necessary or current APS's if available)

Name of Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Details: _____

Any and all information released as a result of signing these forms shall remain absolutely confidential and private except for use under the process of securing a settlement offer.

X _____
Insured
X _____
Insured #2

X _____
Policyowner
X _____
Policyowner (s)

Date: _____

Insurance Company

Address

Re: Insured(s): _____

Policy: # (s): _____

This letter is to serve as authorization to release any and all information on the above referenced policy including policy values, rider, inforce illustrations and verification of coverage to my current financial advisor and broker of record _____.

I agree that this authorization is valid for the maximum period permitted by state law, and that a facsimile or photocopy is as valid as the original.

Insured

Print name

Insured #2

Print name

Owner

Print Name

Title / Relationship

Owner #2

Print Name

Title / Relationship