



LIFE INSURANCE APPLICATION

PROPOSED INSURED:

First Name: Middle Initial Last Name:
Date of Birth: Gender: Male ☐ Female ☐ Social Security Number:
Driver's License State: Driver's License Number: Driver's License Expiration:
Height on Driver's License: ft inches Weight on Driver's License: lbs
Country of Birth: State of Birth: US Citizen: YES ☐ NO ☐
Cell Phone Number: Ok to Text: YES ☐ NO ☐ Email Address:
Physical Address:
Mailing Address same as Physical Address: YES ☐ NO ☐

If no, Mailing Address:

Monthly Budget for Policy: REQUIRED FACE VALUE OF POLICY:

Insurance Policy :

10 Year Term Life ☐ Whole Life ☐
20 Year Term Life ☐ Burial Costs Only ☐
30 Year Term Life ☐ Index Universal Life ☐

Will the proposed insured be the Policy Owner? YES ☐ NO ☐

Is there a Policy Co-Owner or successor Policy Owner? YES ☐ NO ☐
(Naming a successor owner allows for ownership to pass to that person if they are alive when the owner dies)

Is the proposed insured currently employed: YES ☐ NO ☐ Household Annual Income:

Employer's Name: Occupation:

Number of years with current employer? Years ☐ Months ☐ Basic Duties:

Total Life Insurance coverage in force or currently applied for on spouse / domestic partner /civil union partner:

SUCCESSOR OWNER:

First Name: Middle Initial Last Name:
Date of Birth: Gender: Male ☐ Female ☐
Cell Phone Number: Ok to Text: YES ☐ NO ☐ Email Address:
Physical Address:

BENEFICIARY INFORMATION:

Full Name	Relationship	Percentage (%)



FINE BREGER INSURANCE AGENCY, LLC

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Email: jbreger@farmersagent.com

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BENEFICIARY 1:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

BENEFICIARY 2:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

BENEFICIARY 3:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

CONTINGENCY BENEFICIARY:

Full Name	Relationship	Percentage (%)

CONTINGENCY BENEFICIARY 1:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

CONTINGENCY BENEFICIARY 2:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

CONTINGENCY BENEFICIARY 3:

First Name:

Middle Initial

Last Name:

Date of Birth:

Gender: Male ☐ Female ☐

Cell Phone Number:

Email Address:

Physical Address:

Have you ever filed bankruptcy in the past seven (7) years? YES ☐ NO ☐

Is this a business related sale: YES ☐ NO ☐

TEMPORARY INSURANCE AGREEMENT APPLICATION:

Is any proposed insured less than 15 days old or more than 70 years of age as of the date of this application?
YES ☐ NO ☐

Has the proposed insured ever been told by a member of the medical profession that he / she had or consulted with a physician for or received medical treatment for any of the following: disorder of the heart or blood vessels, angina, heart attack, stroke, cancer, tumor, Acquired Immunity Deficiency Syndrome (AIDS), AIDS related complex (ARC) or any other immunology disorder, drug dependency, or alcohol dependency?
YES ☐ NO ☐

Within the past two years, has the proposed insured been hospitalized for more than five days for any reason?
YES ☐ NO ☐

Has the proposed insured ever applied for life insurance which has been declined, rated or modified in any way?
YES ☐ NO ☐

Within the past ninety days has the proposed insured been unable to perform the normal duties of his/her occupation for 15 or more working days because of illness or injury?
YES ☐ NO ☐

Primary Physician Information:

First Name: Middle Initial Last Name:

Cell Phone Number: Email Address:

Physical Address:

Reason for last visit: Date of Last Visit:

PERSONAL HISTORY

Have you, in the past five years, used Tobacco or Nicotine products in any form (e.g. cigarettes, pipes, cigars, snuff, chewing tobacco or nicotine delivery device such as gum or patch etc.)
YES ☐ NO ☐

Have you, in the past 10 years, had your driver's license suspended, revoked, pled guilty to, or been convicted of reckless driving, or driving under the influence (DUI/DWI)?
YES ☐ NO ☐

Have you, in the past five years, pled guilty to or had any other driving conviction(s) (e.g. speeding, cell phone/texting, accident, etc.)?
YES ☐ NO ☐

Have you, in the past ten years, pled guilty to or been convicted of a felony or misdemeanor, or are such charges pending against you, or are you currently on parole or probation?
YES ☐ NO ☐

Have you had an application for Life, accident or health insurance or reinstatement of a policy, declined, postponed, cancelled or issued other than as applied for?
YES ☐ NO ☐

Are you a member of the military, military reserve, or National Guard (active or inactive) or do you have a written agreement to become a member at a future date?
YES ☐ NO ☐

Within the next two years, do you plan to travel, work or reside outside the US?
YES ☐ NO ☐

Have you in the past two years, flown as a student pilot, pilot or crewmember (or do you plan to in the next two years)?
YES ☐ NO ☐

Have you in the past two years or do you plan to in the next two years, to take part in hang gliding, para sailing, para kiting, parachuting, skydiving, ultralight, soaring, ballooning, bungee jumping, rock or mountain climbing, organized racing by automobile, motorcycle, powerboat or snowmobile, or underwater diving?
YES ☐ NO ☐

MEDICAL HISTORY

Have you lost more than 15 pounds over the past 12 months
YES ☐ NO ☐

Do you have any congenital or birth disorders including blindness, deafness, missing limb(s), heart defect, Down's Syndrome, Autism or any other congenital disorder?
YES ☐ NO ☐

Have you, in the past five years, consulted with been diagnosed or treated by a member of the medical profession or hospitalized, or taken medication for:

High blood pressure or high cholesterol / hyperlipidemia?
YES ☐ NO ☐

Chest pain, angina, heart attack, heart murmur, stroke or transient ischemic attack/mini stroke (TIA), irregular heart beat/rhythm, other circulatory or heart disorder or coronary artery / heart disease / atherosclerosis?
YES ☐ NO ☐

Cancer, tumor, mass, skin cancer, including melanoma, leukemia, lymphoma, colon polyp or any malignant or benign growths?
YES ☐ NO ☐

Diabetes, impaired glucose tolerance (pre-diabetes), gestational diabetes, anemia or other blood disorders (including HIV), or disease or disorder of the thyroid, pituitary or adrenal glands?
YES ☐ NO ☐

Disorder of the liver, pancreas, digestive system or spleen including hepatitis, ulcers, intestinal bleeding, cirrhosis, fatty liver, or weight loss surgery?
YES ☐ NO ☐

Depression, anxiety, stress, eating disorder (anorexia or bulimia), post-traumatic stress disorder, attention deficit / attention deficit hyperactivity, bipolar or other psychiatric or mental health disorder?
YES ☐ NO ☐

Seizures, paralysis, multiple sclerosis, memory loss or other disease or disorder of the nervous system?
YES ☐ NO ☐

Asthma, chronic obstructive pulmonary disease, emphysema, chronic bronchitis, sleep apnea or any other disease or disorder of the lungs or respiratory system?
YES ☐ NO ☐

Kidney, bladder, urinary, reproductive organ (other than contraceptive medication) or prostate disorder?
YES ☐ NO ☐

Arthritis, fibromyalgia, gout, back or joint pain or muscular disorder, or Lupus?
YES ☐ NO ☐

Have you, in the past five years, been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having Human Immunodeficiency Virus (HIV) antibodies or antigens or Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or any other immune deficiency disorder, or have you tested positive for HIV antibodies or antigens?

YES ☐ NO ☐

Have you ever used, or been treated for the use of amphetamines, barbiturates, cocaine, marijuana, opiates, hallucinogens or any other illegal drugs or have you been treated by or consulted a member of the medical professional for abuse of prescription drugs?

YES ☐ NO ☐

Have you ever been advised by a medical professional to reduce or stop drinking alcohol, or received treatment of any kind for the use of alcohol?

YES ☐ NO ☐

Do you currently drink alcoholic beverages?

YES ☐ NO ☐

Have you, in the past five years, been disabled, received disability income benefits, or been unable to work or perform and carry out your normal daily functions for any reason other than maternity leave or recover from minor surgery?

YES ☐ NO ☐

Have you, in the past five years, been diagnosed by a medical professional for any other illness, disease, or injury, not included in your answers to any of the preceding questions?

YES ☐ NO ☐

Have you, in the past five years, been admitted or advised to be admitted to any hospital or health care facility, or undergone or been advised to have surgery, biopsies, treatment or medical test that are not included in your answers to any of the preceding questions?

YES ☐ NO ☐

Have you ever attempted suicide?

YES ☐ NO ☐

Parent 1:

Living YES ☐ NO ☐ Current Age:

If or while living: All Diseases/Disorders (as diagnosed by a medical professional)

- | | |
|---|---|
| ☐ Alzheimer's Disease | ☐ Huntington's disease |
| ☐ Cancer | ☐ Motor Neuron Disease including ALS |
| ☐ Coronary artery disease / Heart Attack / Myocardial infarction | ☐ Parkinson's Disease |
| ☐ Familial Adenomatous polyposis | ☐ Polycystic Kidney Disease |
| | ☐ None of the Above |

Parent 2:

Living YES ☐ NO ☐ Current Age:

If or while living: All Diseases/Disorders (as diagnosed by a medical professional)

- | | |
|---|---|
| ☐ Alzheimer's Disease | ☐ Huntington's disease |
| ☐ Cancer | ☐ Motor Neuron Disease including ALS |
| ☐ Coronary artery disease / Heart Attack / Myocardial infarction | ☐ Parkinson's Disease |
| ☐ Familial Adenomatous polyposis | ☐ Polycystic Kidney Disease |
| | ☐ None of the Above |

If YES to any, how old were they when they got diagnosed?



Sibling 1:

Living YES ☐ NO ☐ Current Age:

If or while living: All Diseases/Disorders (as diagnosed by a medical professional)

- | | |
|---|---|
| ☐ Alzheimer's Disease | ☐ Huntington's disease |
| ☐ Cancer | ☐ Motor Neuron Disease including ALS |
| ☐ Coronary artery disease / Heart Attack / Myocardial infarction | ☐ Parkinson's Disease |
| ☐ Familial Adenomatous polyposis | ☐ Polycystic Kidney Disease |
| | ☐ None of the Above |

Sibling 2:

Living YES ☐ NO ☐ Current Age:

If or while living: All Diseases/Disorders (as diagnosed by a medical professional)

- | | |
|---|---|
| ☐ Alzheimer's Disease | ☐ Huntington's disease |
| ☐ Cancer | ☐ Motor Neuron Disease including ALS |
| ☐ Coronary artery disease / Heart Attack / Myocardial infarction | ☐ Parkinson's Disease |
| ☐ Familial Adenomatous polyposis | ☐ Polycystic Kidney Disease |
| | ☐ None of the Above |

Sibling 3:

Living YES ☐ NO ☐ Current Age:

If or while living: All Diseases/Disorders (as diagnosed by a medical professional)

- | | |
|---|---|
| ☐ Alzheimer's Disease | ☐ Huntington's disease |
| ☐ Cancer | ☐ Motor Neuron Disease including ALS |
| ☐ Coronary artery disease / Heart Attack / Myocardial infarction | ☐ Parkinson's Disease |
| ☐ Familial Adenomatous polyposis | ☐ Polycystic Kidney Disease |
| | ☐ None of the Above |

EXISTING INSURANCE DETAILS:

Insured's Name:

Company Name:

Policy Number:

Amount of Life Coverage:

Issue Date:

Product Type (Type of Policy):

Amount of ADB:

Replacement: YES ☐ NO ☐

Owner:

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?

YES ☐ NO ☐

Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?

YES ☐ NO ☐