INDIVIDUAL INSURANCE SOLUTIONS

Confidential Fact Finder

Not an application for life insurance.

Personal Information

Name: _____ ☐ Male ☐ Female

Date of Birth: _____ Citizenship: _____ Driver's License State and Number: _____

Current Address: _____ Mobile Phone Number: _____

City: _____ State: _____ Zip: _____ Email: _____

Occupation, Type of Business, Position: _____ Ownership Type: ☐ Individual ☐ Trust ☐ Business

Net Worth: _____ Annual Income: _____ Proposed Amount of Insurance: _____ Premium Range: _____

State of Policy Ownership: _____ Is This a Replacement Policy? ☐ Yes ☐ No

In-Force Insurance

Company Name	Replacement	Death Benefit	Plan	Year Issued	Current Premium	1035 Amount
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					
	☐ Yes ☐ No					

Have you ever been declined or rated? If so, please explain: _____

Company Name: _____ Year: _____ Reason: _____ Rating: _____

Medical History

Do you have access to patient portal through your primary care physician? ☐ Yes ☐ No

Height: _____ Weight: _____ Have you gained or lost more than 10lbs in the last 12 months? ☐ Yes ☐ No

If yes, please provide details including how and why? _____

Does your mother, father, or sibling(s) have a history of cancer, diabetes and/or heart disease? ☐ Yes ☐ No

If yes, please indicate type of history, age at onset, current age or age at death if deceased. _____

_____

Medical History cont.

Primary Physician Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Specialist Physician: _____ Phone: _____

Please list all prescriptions and over the counter medications and dosages currently being taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

Has your doctor recommended you have any additional or follow-up or pending appointments or tests? ☐ Yes ☐ No

If Yes, Please Explain: _____

_____

Have you ever been diagnosed with or treated for any of the following (check all that apply, may require additional information to assess)?

1 ☐ Heart Disease
2 ☐ Chest Pain Related to Cardiovascular Disease
3 ☐ High Blood Pressure
4 ☐ Heart Murmur
5 ☐ Stroke/TIA
6 ☐ Cancer
7 ☐ Diabetes
8 ☐ Lupus
9 ☐ Ulcerative Colitis or Crohn's
10 ☐ Respiratory Disorder
11 ☐ Kidney Disease
12 ☐ Hepatitis/Liver Disease
13 ☐ Nervous System Disorder Brain
14 ☐ Spinal Cord Disorder
15 ☐ Depression/Anxiety
16 ☐ Alzheimer's or Dementia
17 ☐ Sleep Apnea
18 ☐ Other

Number	Treatment/Prognonsis/Details	Date of Onset/Date of Recovery	Treating MD Name (address and phone if not above) If Hospitalized, Include Name/Address of Hospital

Lifestyle Information

Avocations (may need additional information to assess)

Check if you participate in any of the following avocations:

☐ Aviation of Any Kind
☐ Mountain or Rock Climbing
☐ Extreme Sports
☐ Sky Diving
☐ Scuba Diving
☐ Motorcycle or Auto Racing

Have you ever flown or intend to fly in the next 2 years as a student pilot, licensed pilot, or crew member in any aircraft, including ultralight planes? ☐ Yes ☐ No

Tobacco/Nicotine Usage ☐ Check here if not applicable

Have you ever smoked cigarettes? ☐ Yes ☐ No If yes, date of last usage: _____

Have you ever used vaping products (e.g. E-cigarettes)? ☐ Yes ☐ No If yes, date of last usage: _____

Have you used other tobacco or nicotine containing products (e.g. cigar, pipe, snuff, nicotine gum, or patch)? ☐ Yes ☐ No

If yes, provide type and date of last usage: _____

Marijuana & CBD Oil Usage ☐ Check here if not applicable

Do you use marijuana? ☐ Yes ☐ No If yes, complete the following:

Purpose: ☐ Recreational/Social

Frequency: _____times per ☐ Day ☐ Month ☐ Year

Exact Type: _____ mg _____

Delivery Method: ☐ Ingested ☐ Vaporized ☐ Inhaled

Date Last Used: _____ Why: _____

Do you use use CBD oil? ☐ Yes ☐ No If yes, complete the following:

Frequency: _____times per ☐ Day ☐ Month ☐ Year

Exact Type: _____ mg _____

Delivery Method: ☐ Ingested ☐ Vaporized ☐ Inhaled

Date Last Used: _____ Why: _____

Describe your exercise routine, such as walking, running, treadmill, swimming, aerobics, strength training, cycling, sports or yoga.

_____

Please indicate which of the following apply to your driving history:

☐ Convicted of 1 or more moving violations in the past 2 years ☐ Convicted of driving while intoxicated or otherwise impaired
☐ License is currently revoked or suspended ☐ License is currently revoked or suspended

Have you ever been convicted of a DUI? ☐ Yes ☐ No If so, when? Please list all _____

_____

Additional Information

Please provide any additional information you feel is necessary: _____

_____

_____

_____