



INSURANCE DATA COLLECTION WORKSHEET/CASE DEVELOPMENT

Agent Name: _____ Phone: _____ Date: _____

Owner/Proposed Insured Name: _____ M F Date of Birth: _____

Face Amount: _____ Premium if Known: _____ IUL GUL Term While Life

SSN: _____ Phone # : _____ Height _____ Weight _____

Email Address: _____

Home Address: _____

Occupation: _____ Annual Income: _____ Net Worth: _____

DL No: _____ State: _____ Country of Birth: _____ US Citizen YES NO

Employer: _____ Address: _____

Bank: _____ Routine No: _____ Acct No: _____

Doctor's Name: _____ Phone No: _____

Address: _____

Date of Last visit: _____ Reason for Visit: _____ Outcome: _____

Dad:{Living} YES NO Age _____ Age at the time of Death: _____ Cause of Death: _____

Mom:{Living} YES NO Age _____ Age at the time of Death: _____ Cause of Death: _____

Spouse: _____ DL# _____ Date of Birth: _____

Phone No: _____ Face Amount: _____ Premium Account: _____

SSN: _____ Height: _____ Weight: _____ Gender: M F

Email: _____ Dr's Name: _____ Dr's #: _____

BENEFICIARY

NAME:	NAME:	NAME:
DOB:	DOB:	DOB:
SSN:	SSN:	SSN:
PHONE#:	PHONE#:	PHONE#:
EMAIL:	EMAIL:	EMAIL:

CHILDREN

NAME: _____ DATE OF BIRTH: _____ SSN: _____ DR'S NAME: _____ DR'S PHONE#: _____ OUTCOME OF APPOINTMENT: _____ MEDS: _____	NAME: _____ DATE OF BIRTH: _____ SSN: _____ DR'S NAME: _____ DR'S PHONE#: _____ OUTCOME OF APPOINTMENT: _____ MEDS: _____
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NAME: _____ DATE OF BIRTH: _____ SSN: _____ DR'S NAME: _____ DR'S PHONE#: _____ OUTCOME OF APPOINTMENT: _____ MEDS: _____	NAME: _____ DATE OF BIRTH: _____ SSN: _____ DR'S NAME: _____ DR'S PHONE#: _____ OUTCOME OF APPOINTMENT: _____ MEDS: _____
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Do you currently smoke cigarettes? Yes No

If no, did you ever smoke? Never Quit (Date) _____

Or use any other tobacco products (e.g. nicotine patch/gum, cigars, pipe, snuff/chew, e-cig, marijuana)? Yes No

If yes, please provide details: _____

When did you last use any form of tobacco? _____ (Month) _____ (Year) Type used last? _____

CHECK ALL THAT APPLIES AND ANSWER THE CORRESPONDING QUESTIONS.

Heart Conditions- Please check all that apply:

- Coronary Artery Disease Heart Attack Congestive Heart Failure
- Atrial Fibrillation Cardiomyopathy Valve Disease
- Valve Replacement

Which condition (s) and date(s) of diagnosis

Hypertension / High Blood Pressure

Current Blood Pressure Reading _____ Average Blood Pressure Reading _____

Stroke/ TIA / TIA symptoms: Date of symptom and diagnosis _____ Recurrence of symptoms _____

Diabetes Type I (Juvenile) Type II

Date of Diagnosis _____ Current Glucose and/or Hemoglobin A1C Reading _____

Do you use Insulin? Units per day

In **combination with Diabetes**, do you have any of the following:

- Tingling
- Numbness
- Neuropathy
- Skin Ulcers
- Coronary Artery Disease
- Cellulitis
- Visual Changes
- Retinopathy
- Kidney Or Liver Problems
- Organ
- Heart Disease
- TIA/Stroke
- Peripheral Vascular Disease

Cancer

Type Stage or Grade Date of diagnosis

Date of Last Treatment Type of Treatment? Any treatment at this time?

MVR: Driving infractions or felony charges in past 10 years

Any other health conditions? Provide details:

Date of your last physician office visit? Reason for visit

Do you have any surgery that is pending or has been recommended?

Please Explain

Current Medications (Daily usage of prescription narcotics are an automatic decline.)

Have you been prescribed medication that you aren't currently taking?

Please Explain

Please list medications you are currently taking.(Please include over-the-counter medications that are used daily)

Name of Medication	Dosage	Condition	Start Date of Medication
1. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7. <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>