

Client Data Form

PROPOSED INSURED INFORMATION

First Name: _____ Middle Int.: _____ Last Name: _____
 State: _____ DOB: ___/___/___ Gender: M F Coverage Amount: \$ _____
 Term Years: _____ Is this a replacement? Y N Will the insured own this policy? Y N
 Riders: Accidental Death Benefit Waiver of Premium Child Term Amount: \$ _____ *(\$1,000 increments up to \$25,000)*

CLIENT INFORMATION

_____ (____) _____ - _____ (____) _____ - _____ (____) _____ - _____
 SSN # Home Phone Mobile Phone Work Phone Driver's License # License State

 Email Address Address City State Zip
 _____ / _____ / _____
 Owner's Full Name DOB or Trust Date SSN # / TIN # Relationship Email Address
(If other than insured)

 Address City State Zip
(If other than insured)
 Is the client a U.S. Citizen? Y N Purpose of Insurance: Personal Business

EXISTING/PENDING COVERAGE

Does the client have any existing or pending life insurance or annuities? *If yes, please fill in the fields below.* Y N

Carrier	Amount	Policy Number	Issue Year	Beneficiary	Replacement
_____	\$ _____	_____	_____	_____	<input type="radio"/> Y <input type="radio"/> N
_____	\$ _____	_____	_____	_____	<input type="radio"/> Y <input type="radio"/> N

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your exist policy or contract? Y N
 Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Y N
 Reason for replacement: _____
 Total Accidental Death Insurance inforce with all companies: \$ _____

BENEFICIARY INFORMATION

Name/Relationship	Primary/Contingent	Percent	DOB	SSN # / TIN #
_____	_____	_____	___ / ___ / _____	____ - ____ - _____
_____	_____	_____	___ / ___ / _____	____ - ____ - _____

AGENT ONLY SECTION

What is the source of funds for the initial premium? _____

What is the source of funds for future premiums? _____

Did you see the proposed insured at point-of-sale? Y N

Is the proposed insured an active duty service member of the US Armed Forces (including National Guard and Reserve)? Y N

Is the policyowner, or the person to whom this policy was sold, an active duty service member of the United States Armed Forces (including National Guard and Reserve)? Y N

HEALTH INFORMATION

1.) Height: ____ feet ____ inches 2.) Weight: ____ lbs (current weight plus 1/2 of any weight loss in the last year)

3.) Does the proposed insured use or have they ever used tobacco or nicotine? _____

3a.) If yes, what type, frequency and when last used? _____

3b.) If cigar use will the insured test positive for nicotine? _____

4.) Has any parent or sibling of the proposed insured had, been diagnosed with, or died from cardiovascular disease and/or cancer prior to age 65? *If yes, fill out the following for each applicable parent and/or sibling:* Y N

Relationship	Age at Death or Diagnosis	Type: Cardiovascular or Cancer	Result: Death or Diagnosis	
_____	_____	_____	<input type="radio"/> Death	<input type="radio"/> Diagnosis
_____	_____	_____	<input type="radio"/> Death	<input type="radio"/> Diagnosis
_____	_____	_____	<input type="radio"/> Death	<input type="radio"/> Diagnosis
_____	_____	_____	<input type="radio"/> Death	<input type="radio"/> Diagnosis

5.) Has the client ever been told he/she has high blood pressure (hypertension)? Y N

5a.) Does the client currently take medication or have any history or treatment for high blood pressure? Y N

5b.) If yes, what was the client's usual blood pressure reading for the past 6 months? ____ / ____

5c.) If the client does not know his/her reading, select the option that best describes his/her blood pressure over the past 12 months:

very well-controlled
 reasonably well-controlled
 not well-controlled

6.) Has the client had more than 3 speeding tickets and/or moving violations in the past 3 years; OR had a DUI, license suspension, or revocation in the past 5 years? Y N

7.) Has the client ever been diagnosed with, or received treatment/advice for, any of the following? Y N

AIDS, ARC, HIV positive	Multiple Sclerosis (MS)	Rheumatoid Arthritis (RA)
Emphysema/COPD	Barrett's Esophagus	Crohn's Disease
Liver Failure	Heart Disease	Hepatitis B
Alcoholism	Parkinson's Disease	Sleep Apnea
Epilepsy/Seizure	Lupus	Diabetes
ALS (Lou Gehrig's Disease)	Heart Failure	Hepatitis C (active)
Gastric Bypass/Lap Band	Peripheral Artery/Vascular Disease (PAD)/(PVD)	Stroke/Transient Ischemic Attack (TIA)
Melanoma	Cancer (except certain skin cancers)	Drug Abuse
Atrial Fibrillation	Heart Valve Replacement	Kidney Disease
Heart Attack		Ulcerative Colitis (UC)

8.) Has the proposed insured used marijuana in the last 5 years? Y N

9.) Has the client ever had an application for life or health insurance declined, postponed, modified, or rated or offered other than as applied for? Y N



My selection of the agree/submit box below, states that I agree to the following:

1. I am a duly licensed and appointed (if appointment is required) life insurance agent in the state in which the applicant resides and in the state in which the policy, if one is issued, will be delivered.
2. The plan and amount of insurance identified is suitable in view of the owners' insurance needs and financial objectives.
3. The information provided is complete, accurate, and correctly recorded.
4. All required forms (including privacy notices, if necessary) have been or will be provided to the applicant.
5. I authorize Vive to obtain such administrative information necessary to complete any life insurance application resulting from this submission.
6. I will not deliver the policy unless I have completed my review and am satisfied that the policy, application, and all attached papers, if any, are complete and accurate.

I agree to the terms as stated above:

Signature: _____

Date: _____

