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 *(If other than insured)*

___ / ___ / _____ DOB or Trust Date

___ - __ - ____ SSN # / TIN #

___________ Relationship

____________________ Email Address

____ Address *(If other than insured)* City

________ State

_______ Zip

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
____________________	$__________	_______________	_______	_________________	○ Y ○ N
____________________	$__________	_______________	_______	_________________	○ Y ○ 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
____________	____________	____________	○ Death ○ Diagnosis
____________	____________	____________	○ Death ○ Diagnosis
____________	____________	____________	○ Death ○ Diagnosis
____________	____________	____________	○ Death ○ 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
Emphysema/COPD
Liver Failure
Alcoholism
Epilepsy/Seizure Lupus
ALS (Lou Gehrig's Disease)
Gastric Bypass/Lap Band
Melanoma
Atrial Fibrillation Heart Attack

Multiple Sclerosis (MS) Barrett's
EsophagusHeart Disease
Parkinson's Disease
Bipolar Disease
Heart Failure
Peripheral Artery/Vascular Disease
(PAD)/(PVD)
Cancer (except certain skin cancers)
Heart Valve Replacement

Rheumatoid Arthritis (RA) Crohn's
Disease
Hepatitis B
Sleep Apnea
Diabetes
Hepatitis C (active) Stroke/Transient
Ischemic Attack (TIA)
Drug Abuse
Kidney Disease 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

NO CASE IS TOO LARGE, TOO SMALL OR TOO COMPLICATED

Submission Agreement

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 ______________

Agent Name ______________________________

Client Name ______________________________

Applied for:

Company ______________________________

Product ______________________________

Risk Class ______________________________