UNDERWRITING APPRAISAL

This form will assist your financial advisor in providing you with a more accurate rate for proposed life insurance, disability insurance, long term care insurance or an immediate annuity. The information provided will be used to screen insurance companies in an effort to provide the most competitive rate and rate class possible. This form is not an application for insurance or other financial product.

Personal Information – *Please Complete for Each Client*			
Full Name	Gender	Marital Status	Birth Date

Street Address	City	State	Zip Code

Height	Weight	Social Security Number	Country of Citizenship (Detailed explanation if not USA)

Occupation and Employer	Earned Income	Net Worth

Purpose of Insurance (Income Replacement, Family Needs, Key Person, Estate Planning, Executive Benefits, etc.)

Proposed Plan (Term, UL, VUL, DI, LTC, SPIA, etc.)	Benefit Amount	Replacement?

Background Information		
Please provide full details in Remarks for any "yes" answers.	Yes	No
1) Have you flown as a pilot within five years, or are any such flights planned in the future?	☐	☐
2) In the past five years have you engaged in racing, scuba diving, hang gliding, mountain climbing, sky diving or other activity that might impact your insurance rate class?	☐	☐
3) Do you intend to travel or reside outside of the United States in the next five years?	☐	☐
4) Have you had any motor vehicle accidents, DWIs, speeding tickets, or other traffic violations in the past seven years or has your driver's license ever been suspended or revoked?	☐	☐
5) Have you ever been convicted of a felony?	☐	☐
6) Within the past five years have you used any form of tobacco or other nicotine product including a nicotine patch? If yes, include specific details in Remarks on product type, quantity, frequency and last use.	☐	☐
7) Have you had a parent or sibling who had and/or died from cancer, diabetes, stroke, heart or kidney disease, or who committed suicide? If yes, show age of onset and/or age death occurred in Remarks.	☐	☐
8) Have applied for insurance and had the policy rated, postponed or declined?	☐	☐
Medical Information		
9) Within the last 10 years, have you had, been treated for, or been diagnosed as having a heart condition, chest pain, stroke, back or neck problem, psychological condition (including, but not limited to, counseling from a mental health or substance abuse provider, and/or psychotherapy) cancer, diabetes, sleep apnea alcohol abuse, or drug dependency?	☐	☐
10) Are you currently taking any prescription medications?	☐	☐
11) In the last five years have you had a blood pressure reading? If yes, provide the reading and date taken in Remarks.	☐	☐
12) In the last five years have you had a cholesterol test performed? If yes, provide the cholesterol level, cholesterol/HDL ratio and date the test was performed.	☐	☐
13) Has your weight changed by more than 10 pounds in the last twelve months?	☐	☐
14) List in remarks below your personal physician's name, address and phone number. Also include any other physician you have seen in the last five years and the reason for the visit.		

Remarks – Use additional pages as needed.