YOUR MARKETPLACE FOR LONG-TERM CARE ~ LIFE ~ DISABILITY & ANNUITIES

OMNIQuote

375 NORTH BROADWAY
JERICHO, NY 11753-2008
1-800-966-6641
INFO@OMNIQUOTE.NET

TERM LIFE INSURANCE ~ APPLICATION REQUEST FORM

BY PHONE
1-800-966-6641

BY FAX
1-800-966-6583

BY MAIL
375 N. BROADWAY
JERICHO,NY 11753-2008

PART 1—YOUR PERSONAL INFORMATION

1. Name: (Last) _____ (First) _____ (Middle) _____
2. Street Address: _____
   City:_____State: _____ Zip Code: _____
3. Mailing Address: (If Different) _____
4. Phone Numbers: Home:_____Business: _____Cell: _____Fax: _____
5. Date Of Birth: __/__/____ Place of Birth: _____ 6. Sex: Male Female
8. Marital Status: Single Married Divorced Widowed Maiden Name:_____
9. Occupation: _____Duties: _____
10. Name of Employer: _____Address: _____City: _____ State:____ Zip: _____
11. Drivers Lic. #: _____State: _____ 12. E-Mail Address:_____

PART 2 — POLICY REQUESTED

13. Insurance Company: _____ 14. Amount of Insurance: _____
15. Premiums Guaranteed For: 10 Years 15 Years 20 Years 25 Years 30 Years Lifetime Other _____
16. Name of Owner, if other than the proposed insured: _____
17. Relationship to Proposed Insured: _____
19. If A Trust, Date of Trust: _____ 20. Name of Trustee: _____
21. Billing Preference: Annually Semi-Annual Quarterly Monthly (only debited from bank account)
22. Send billing notices to: Proposed Insured Owner Other _____
23. Address: _____City: _____State: _____Zip: _____

PART 3 — HEALTH INFORMATION

24. Height: ____feet ____Inches 25. Weight: _____Lbs. 26. Pounds Gained ____ or Lost ____ in past 12 Months.
27. Name of Personal Physician: _____ Telephone #: _____
28. Address: _____City: _____ State: _____Zip: _____
29. Date of Last Visit: _____ 30. Reason for Visit: _____
31. Has the proposed insured EVER used any form of Tobacco or nicotine products? ..... Yes No
    If Yes: Type used _____ Daily Amount _____ Date Last Used _____
32. If known, please provide the proposed insured's recent #'s for the following: Cholesterol _____HDL Ratio _____

PLEASE GIVE FULL DETAILS TO ANY "YES" ANSWERS OR USE A SEPARATE SHEET

33. Has the proposed insured or family member (Parent or Sibling) ever had Heart Disease or Cancer?... Yes No
    Details_____
34. Has the proposed insured even been diagnosed with High Blood Pressure, Stroke, Epilepsy, Mental or Nervous Disorder, Diabetes, Lung or Respiratory Disorder, Gastric or Intestinal Disorder, Kidney or Urinary Tract Disorder, Disorder of the Blood, or Lymph Nodes, or any Disease of the Reproductive Organs? ..... Yes No
    Details:_____
35. Has the proposed insured ever been diagnosed or treated as having Acquired Immune Deficiency Syndrome (AIDS); AIDS Related Complex or AIDS related conditions? ..... Yes No

36. Has the proposed insured ever used heroin, cocaine, LSD, PCP, amphetamines, barbiturates, derivatives of the drugs or any other controlled substance except as prescribed by a physician? ..... Yes No

37. Has the proposed insured ever received, or advised to seek, counseling for Alcohol or Drug Use? .. Yes No

38. Is the proposed insured taking or has been advised to take any medication? ..... Yes No

MEDICATION	TREATMENT FOR	DOSAGE	INITIAL TREATMENT DATE

39. Has the proposed insured ever been hospitalized, consulted, been examined or treated by any other Physician, Psychiatrist or Medical Practitioner not disclosed in a previous question?..... Yes No

NAME OF PHYSICIAN	CONDITION TREATED FOR	TREATMENT RECEIVED	TREATMENT DATES	PHYSICIAN'S NAME & ADDRESS

PART 4 — BENEFICIARIES

	NAME	RELATIONSHIP	%	DATE OF BIRTH	
PRIMARY BENEFICIARY					
CONTINGENT BENEFICIARY					

PART 5 — LIFE INSURANCE IN FORCE ON PROPOSED INSURED

INSURANCE COMPANY	AMOUNT OF INS.	DATE OF ISSUE	POLICY NUMBER	BEING REPLACED	(B) BUSINESS (P) PERSONAL	NEXT DUE DATE
				☐ YES ☐ NO		
				☐ YES ☐ NO		
				☐ YES ☐ NO		

40. Has the proposed insured applied for insurance with any company within the past 12 months? ..... Yes No

41. Has the proposed insured ever had a policy issued other than as applied for? ..... Yes No

Details: _____

PART 6 — GENERAL INFORMATION

42. Is the Proposed insured a Citizen of The USA? (If no, provide country, type of visa & expiration date.. Yes No

43. Has the proposed insured in the past 2 yrs traveled outside the USA, or plan to in the next 2 years?.. Yes No

44. Has the proposed insured ever been convicted of a misdemeanor or a felony?..... Yes No

45. Has the proposed insured ever filed for bankruptcy?..... Yes No

46. Has the proposed insured ever been convicted of reckless driving, driving under the influence, had a suspended License or License revoked, or in the past 5 years has had 2 or more moving violations or accidents? Yes No

47. Has the proposed insured engaged in flying as a pilot, student pilot, or crewmember, or intends to?... Yes No

48. Has the proposed insured ever engaged in ballooning, parachuting, hang gliding, vehicle racing, scuba diving, mountain climbing or any similar sport or avocation, or intends to?..... Yes No

49. Has the proposed insured requested or received Worker's compensation disability income payment?. Yes No

Details on Yes answers 42-49: _____

PART 7 — FAMILY HISTORY & PERSONAL PROFILE

50. Annual earned income for proposed insured $_____ Unearned income $_____ Est.Net Worth $_____

FAMILY	NUMBER	AGE IF LIVING	AGE AT DEATH	CAUSE OF DEATH
Father	N/A			
Mother	N/A			
Brothers				
Sisters				