

# LIFE INSURANCE FACT FINDER

## CLIENT PROFILE

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### Section 1:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  M or  F

Occupation: \_\_\_\_\_ Annual Earned Income: \$ \_\_\_\_\_

Net worth: \$ \_\_\_\_\_ Annual Unearned Income: \$ \_\_\_\_\_

Tobacco/Nicotine Use: No  Yes   Cigarette  Cigar  Chew  Hooka  Pipe  Vape Frequency: \_\_\_\_\_

Marijuana Use: No  Yes  How Used:  Smoked  Ingested  Vape

Frequency of Use: \_\_\_\_\_ Reason for Use:  Recreational  Medical condition (specify) \_\_\_\_\_

Life Insurance Type:  Universal Life  Term Life (years) \_\_\_\_\_  Whole Life  Survivorship

Face Amount: \_\_\_\_\_ Insurance Carrier: \_\_\_\_\_

### Section 2:

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

Health Conditions: (high blood pressure, cholesterol, cancer, heart disorder, diabetes, circulatory disorder, liver disorder, mental/nervous disorder, other). Specify condition, date of onset, status, and other details: \_\_\_\_\_

## CURRENT MEDICATION

Name of Medication	Dosage	Times Per Day	Reason Prescribed

Dates and reasons for doctor visits or hospitalizations in the past five years: \_\_\_\_\_

Family History: Has either parent been diagnosed with or died from Cancer or Heart Disease prior to age 60?

Mother?  Y  N Reason/Condition: \_\_\_\_\_ Living?  Y  N Age: \_\_\_\_\_

Father?  Y  N Reason/Condition: \_\_\_\_\_ Living?  Y  N Age: \_\_\_\_\_

## Personal History of Medical Conditions

Cancer, Date of Diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Heart Disease, Date of Diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Diabetes, Date of Diagnosis \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Other \_\_\_\_\_

Please indicate specifics (if applicable) including treatment, type and stage of cancer, type of control, heart details, etc.

All information is kept confidential.

Page 1 of 2

# LIFE INSURANCE FACT FINDER

Client Name: \_\_\_\_\_

**Request for Attending Physician Information:** Please list all of the physicians that the client has seen within the past 5 years and the reason for each visit. If the client does not have a personal physician, please state so below.

**Primary Doctor:** \_\_\_\_\_

**Complete Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Date and Reason for Last Visit:** \_\_\_\_\_

**Specialty Doctor:** \_\_\_\_\_

**Complete Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Date and Reason for Last Visit:** \_\_\_\_\_

**Specialty Doctor:** \_\_\_\_\_

**Complete Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Date and Reason for Last Visit:** \_\_\_\_\_

**\*\*If additional Physicians need to be listed, please provide the information on a separate page.\*\***

## Section 3:

**U.S. Citizen?**  Y  N If NOT U.S. Citizen, specify the country of citizenship, type of visa, and expiry date:

\_\_\_\_\_

**If traveling outside U.S., specify countries, dates, durations:** \_\_\_\_\_

**Driving, moving, or DUI violations in past 5 years?** N  Y  Instances/Dates: \_\_\_\_\_

**Avocations:**  Aviation  Scuba Diving  Racing  Other – explain \_\_\_\_\_

## Additional Comments:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Financial Professional Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

All information is kept confidential.