



Agent: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Proposed Insured Name: \_\_\_\_\_  M  F Birth or Age: \_\_\_\_\_

Face Amount: \_\_\_\_\_ Max. Premium: \$ \_\_\_\_\_ / year  UL  WL  Term  Survivorship

Do you currently smoke cigarettes?  Y  N If no, did you ever smoke:  Never  Quit (Date): \_\_\_\_\_

Do you currently use any other tobacco products (e.g. nicotine patch, cigars, pipe, snuff, Nicorette gum...):  Y  N

If Yes, please provide details: \_\_\_\_\_

When did you last use any form of tobacco: \_\_\_\_ (Month) \_\_\_\_ (Year) Type used last: \_\_\_\_\_

(1) Do you presently use alcohol?  Yes  No If no, date of last alcohol use: \_\_\_\_\_

Quantity	Beer	Wine	Liquor	Dates: From - To
Daily				
Weekly				
Monthly				

(2) Did you ever drink substantially more than now? Yes No If yes, provide details in the following table:

Quantity	Beer	Wine	Liquor	Dates: From - To
Daily				
Weekly				
Monthly				

(3) Have you ever been treated for excessive alcohol use?  Yes  No

If yes, please provide details: \_\_\_\_\_  
Date(s): \_\_\_\_\_

(4) Have you ever been arrested for driving under the influence (DUI) or for driving while intoxicated (DWI)?  Yes  No

If yes, please provide details: \_\_\_\_\_  
Date(s): \_\_\_\_\_

(5) Have you ever experienced any of the following? If yes, please provide details below:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blackouts                 | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Depression                               |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Psychological disorders | <input type="checkbox"/> Emotional Disorder                       |
| <input type="checkbox"/> Delirium Tremens          | <input type="checkbox"/> Hepatitis A, B, or C    | <input type="checkbox"/> Kidney Disease                           |
| <input type="checkbox"/> Protein or Blood in Urine | <input type="checkbox"/> Liver problems          | <input type="checkbox"/> Other medical condition (describe below) |

(6) Do you attend AA or similar?  Yes  No If yes, how often? \_\_\_\_\_

(7) Please provide any additional information that would help us negotiate the lowest rates possible: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_