

Client Data Form



Data form included questions regarding the Proposed Insured's Medical History, Avocation, Foreign Travel, Tobacco and or Marijuana usage. Intended to be used with Vive's Health Analyzer.

1. PROPOSED INSURED'S INFORMATION

Insured's Name First Last MI

DOB / / Gender F M SSN

License State | Number May not be required for all carriers but should be collected State of Residence

At least one phone field is required.

Home Phone Number - - Mobile Phone Number - -

Work Phone Number - - Email

Primary Address City State Zip Code

Is the Proposed Insured a U.S. Citizen? Yes No

Will the insured own this policy? If no, completion Ownership Section. Yes No Purpose of Insurance Personal Business

2. PROPOSED COVERAGE Additional Carrier or State specific questions may be asked on the drop ticket.

Term Years Coverage Amounts \$

Term Years Coverage Amounts \$

Term Years Coverage Amounts \$

Riders Accidental Death Benefit Waiver of Premium Child Term # of Units for Child Rider

Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No

2. PROPOSED COVERAGE cont.

Reason for replacement _____

Total accidental death insurance in force with all companies \$ _____

Does the client have any existing or pending life insurance of annuities? Yes No
If Yes, please fill in the information below.

Carrier	Amount	Policy Number	Issue Year	Replacement
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
	\$			<input type="checkbox"/> Yes <input type="checkbox"/> No

3. POLICY OWNERSHIP

Owner's Name _____ SSN/TIN _____

DOB or Trust Date ____ / ____ / ____ Email _____ Phone Number ____ - ____ - ____

Primary Address _____ City _____ State _____ Zip Code _____

Relationship to Insured _____

4. BENEFICIARY INFORMATION *The total should equal 100% per beneficiary type.*

Name/Relationship	Primary/Contingent	Percent	DOB	SSN/TIN	<i>Optional from drop ticket submission but may be required before policy issue</i>
			-	-	_____
			-	-	_____
			-	-	_____

5. TO BE COMPLETED BY AGENT

What is the source of funds for the initial premium? _____

What is the source of funds for future premiums? _____

How long have you known the Proposed Insured? _____

Are you related to the Proposed Insured? Yes No

5. TO BE COMPLETED BY AGENT cont.

Did you see the proposed insured at point-of-sale? Yes No

Is the proposed insured an active-duty service member of the US Armed Forces (including National Guard and Reserve)? Yes No

Is the Proposed Insured using income from their spouse/domestic partner to justify the coverage applied? Yes No

Is the policy owner or the person to whom this policy was sold an active-duty service member of the US Armed Forces (including National Guard and Reserve)? Yes No

If Yes, what is the spouse/domestic partner's annual income? \$

If Yes, how much life insurance does the spouse/domestic partner have in force? \$

Do the proposed insured and owner read and understand the English language? Yes No

Proposed Insured Annual Income / Net Worth
Required for John Hancock only \$
\$

OPTIONAL information is not required for quoting or submission.

Engaged in scuba diving, sky sports, mountain, rock, cliff, ice climbing or motorsport events? Have in the last 5yrs Plan to in the next 2 years

Plans to travel outside the U.S. in the next 2 years? Yes No If Yes, When: Have flights been booked? Yes No

Additional Comments

6. HEALTH INFORMATION (OPTIONAL) *Needed only when using Vive's Health Analyzer*

Height Feet Inches Weight (*Current weight plus 1/2 of any weight loss in the last year*) lbs.

Has the proposed Insured ever been diagnosed with high blood pressure (hypertension)? Yes No

Does the proposed insured currently take medication or have any history or treatment for high blood pressure? Yes No If Yes, what was the proposed insured's usual blood pressure reading for the past 6 months?

If the proposed insured does not know their reading, select the option that best describes their blood pressure over the past 12 months? Very Well Controlled Reasonably Well Controlled Not Well Controlled

Does the proposed insured use or have ever used tobacco or nicotine (Includes cigar use)? Yes No If Yes, what type, frequency and when was it last used?

If cigar use, will the insured test positive for nicotine? Yes No Has any parent or sibling of the proposed insured had, been diagnosed with, or died from cardiovascular disease and/or cancer prior to the age 65? Yes No

If Yes, fill out the following for each applicable parent and/or sibling:

Relationship	Age at Death or Diagnosis	Type		Result	
		<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Death	<input type="checkbox"/> Diagnosis
		<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Death	<input type="checkbox"/> Diagnosis
		<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Death	<input type="checkbox"/> Diagnosis
		<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Death	<input type="checkbox"/> Diagnosis

Has the proposed insured ever been diagnosed with or received treatment/advice for any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS, ARC, HIV Positive | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Liver Failure |
| <input type="checkbox"/> ALS (Lou Gehrig's Disease) | <input type="checkbox"/> Epilepsy/Seizure | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Gastric Bypass/Lap Band | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Barrett's Esophagus | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Bipolar Disease | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Peripheral Artery/Vascular Disease |
| <input type="checkbox"/> Cancer (except certain skin cancers) | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Rheumatoid Arthritis (RA) |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Diabetes (including Gestational) | <input type="checkbox"/> Hepatitis C (active) | <input type="checkbox"/> Stroke/Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> Drug Use | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Ulcerative Colitis (UC) |

Has the proposed insured had more than 3 speeding tickets and/or moving violations in the past 3 years or had a DUI, license suspension or revocation over the past 12 months? Yes No

Not required for quoting or order submission

Has the proposed insured used marijuana in the last 5 years? If yes, specify: Yes No Frequency

Type Date Last Used

Has the proposed insured ever had an application for life or health insurance declined, postponed, or rated or offered other than as applied for? Yes No

OPTIONAL: Medication information is NOT required for quoting or order submission.
Does the proposed insured currently take any prescription medications? Yes No

If Yes, provide prescription information such as name & dosage, reason prescribed, and date condition was diagnosed.

Prescription Name	Dosage	Reason