# 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 |
|---|---|---|---|---|
| | $ | | | ☐ Yes ☐ No |
| | $ | | | ☐ Yes ☐ No |
| | $ | | | ☐ Yes ☐ 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 *Optional from drop ticket submission but may be required before policy issue* |
|---|---|---|---|---|
| | | | - - | |
| | | | - - | |
| | | | - - | |

## 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 ½ 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 | |
|---|---|---|---|---|---|
| | | ☐ Cancer | ☐ Cardiovascular | ☐ Death | ☐ Diagnosis |
| | | ☐ Cancer | ☐ Cardiovascular | ☐ Death | ☐ Diagnosis |
| | | ☐ Cancer | ☐ Cardiovascular | ☐ Death | ☐ Diagnosis |
| | | ☐ Cancer | ☐ Cardiovascular | ☐ Death | ☐ Diagnosis |

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

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