Client Data Sheet

PLAN:

Amount of Insurance Requested: $_____ Rider: _____ Target Premium: $ _____ Payment: $ _____

Long Term Care: ⚪Yes ⚪No Payment Draw Date: _____ Product Company: _____

PERSONAL INFORMATION:

First Name: _____ Middle Initial: _____ Last Name : _____

Gender: ⚪Female ⚪Male Marital Status: ⚪ Married ⚪Single

Date of Birth: _____-_____-_____ SSN: _____-____-_____ Place of Birth: _____

Citizenship: _____ Status in USA: _____ Visa Type: _____ Years in US:_____

Driver License #: _____ State of Issuance: _____ Expiration Date: ___-___-___

Height: ____ ft. _____ in. Weight: _____ lbs. Major Health Issue: _____

Address: _____City: _____State: _____ Zip Code: _____

Cellular Phone: _____-_____-_____ E-mail Address: _____

Years at this Address: _____ Years _____ Mos

(If Owner is different, please provide Owner info below too)

First Name: _____ Middle Initial: _____ Last Name : _____ Male / Female

Cell # : _____ Email : _____ Relationship:_____

EMPLOYER: (Insured or Owner, Please Circle One)

Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Work Phone: _____-_____-_____ Years Worked: ____ Occupation: _____ Duties: _____

FINANCIAL & EDUCATION: (Insured or Owner, Please Circle One)

Annual Income: $_____ Net Worth: $_____ Liquid Net Worth: $_____

Existing Policy #: _____ Company Name: _____ Amount: $_____ Year Issued: _____

Type of Policy: _____ 1035 Exchange: ⚪Yes ⚪No 1035 Exchange Amount: _____

MEDICAL:

Physician Name: _____ ⚪Non-Smoker ⚪Smoker

Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____-_____-_____ Date/Reason for Last Doctor Visit: _____

Date/Diagnosis/Treatment/Results/Duration(if any): _____

Any plans to travel outside United States recently?: ⚪Yes ⚪No If yes provide information. _____

BENEFICIARIES: (Pick a 2nd addressee - need address, cell# and/or email)

Primary 1 DOB:_____-_____-_____

Full Name: _____ SSN: _____-____-_____ Percentage: _____% Relationship: _____

Primary 2 DOB:_____-_____-_____

Full Name: _____ SSN: _____-____-_____ Percentage: _____% Relationship: _____

Contingent 1 DOB:_____-_____-_____

Full Name: _____ SSN: _____-____-_____ Percentage: _____% Relationship: _____

Contingent 2 DOB:_____-_____-_____

Full Name: _____ SSN: _____-____-_____ Percentage: _____% Relationship: _____

- **#__brothers #__ sisters, their Ages? Age of Mom___, Age of Dad ___, healthy or passed at age___.**

BANK INFORMATION:

Bank Name: _____

Bank Routing #: _____ Bank Account #: _____

Client Signature: _____ Date: _____

☆ **Please attach copy of ID and voided check**