Life Application Information Form

Date: _____

McQueenKalligan Insurance Services, LLC

An icon company

Advisor/Producer Information:				
Name:		Phone #:		
Email:				
Client Information:(All fields required)				
Insured's Full Legal Name:		Date of Birth:		Gender:
US Citizen/Perm Resident: ☐ Y ☐ N	Birth Country/State:	SSN:		Marital Status:
Residence Address:				
City:	State:	Zip:	Cell Phone #:	
Driver's License State:	Driver's License #:	Insured's Email:		
Tobacco Usage: ☐ Y ☐ N (if yes, indicate type , reason, and last date of use):		Marijuana Usage: ☐ Y ☐ N (if yes, indicate how often, recreational or medical and last date of use):		
Has the proposed insured ever been treated for the following? Cancer, Heart Disease, Stroke, Diabetes, or any other major condition/illness (if yes, indicate date of diagnosis and details) ☐ Y ☐ N				
Rate Class, Carrier & Product Information:				
Rate Class:	Type of insurance:(Term Length)	Face Amount:		
Carrier:	Product Name:			
Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (EFT)		Premium Amount: $		
Employment and Income Verification:				
Is the Proposed Insured Currently Employed? ☐ Y ☐ N	If not, indicate status:			
Employer:	Job Title:			
Annual Income: $	Net Worth: $			
Owner and Beneficiary Information:				
If the Insured is Not Owner (Please Complete): Owner is a ☐ Person ☐ Trust ☐ Corporation ☐ Other				
Owner Name:	Social Security #/ Tax ID:			
Address:	City:	State:	Zip:	
Officer/person signing as owner:	Title:			
Cell #:	E-mail:			
Primary Beneficiary Name:	SSN/TIN:	Relationship:	%	DOB/Trust date
Primary/Contingent Beneficiary Name:	SSN/TIN:	Relationship:	%	DOB
Contingent Beneficiary Name:	SSN/TIN:	Relationship:	%	DOB
Replacement Information:				
Does the client currently own any life insurance? ☐ Y ☐ N	If Yes, Is this Policy Replacing any existing coverage? ☐ Y ☐ N			
If insured Has Existing Coverage, Provide Insurance Company(s), Death Benefit(s), year of issue and Policy Number(s):				
If Yes, Indicate Reason for Replacement:				
What is the purpose of this insurance?:(i.e. income replacement, etc.)				
Additional Information:				
Has the insured ever been declined, rated or postponed for life or health insurance? Y ☐ N ☐	How long have you known insured?			
Notes:				